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I. INTRODUCTION

President Obama signed the Patient Protection and Affordable Care Act ("ACA" or "Act"),[1] saying that it stood for "the core principle that everybody should have some basic security when it comes to their health care."[2] The ACA's most visible goal is to expand access to health benefit coverage to a majority of the unin-

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1. Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 20, 26, and 42 U.S.C.).

2. Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, with a Flourish*, N.Y. TIMES, Mar. 24, 2010, at A19.

sured.[3] Nonetheless, underlying this goal is an equally important objective: "bending the cost curve" or reducing the rate of increase in health care costs, which total about $2.6 trillion or almost eighteen percent of GDP.[4] The President and many economists saw controlling health care costs as an important step toward economic recovery.[5] Although the Act does not directly regulate the costs of care, many of its provisions are intended to develop new ways to slow both public and private spending for health care, especially for chronic diseases,[6] which are reported to account for the

3. *See* PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH REFORM 239-41 (2011); Theodore Marmor et al., *The Obama Administration's Options for Health Care Cost Control: Hope Versus Reality,* 150 ANNALS INTERN. MED. 485, 485 (2009); COMM. ON HEALTH INSURANCE STATUS AND ITS CONSEQUENCES, INSTITUTE OF MEDICINE, AMERICA'S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE 49 (2009) ("[H]ealth insurance coverage is integral to health care access and health.").

4. David M. Cutler et al., *Why Health Reform Will Bend the Cost Curve*, COMMONWEALTH FUND, Dec. 7, 2009, 6, *available at* http://www.commonwealthfund.org/Publications/Issue-Briefs/2009/Dec/Why-Health-Reform-Will-Bend-the-Cost-Curve.aspx; Anne B. Martin et al., *Growth in US Health Spending Remained Slow in 2010; Health Share of Gross Domestic Product Was Unchanged from 2009*, 31 HEALTH AFFS. 208, 208-09 & exhibit 1 (2012). The Act includes a finding by the Senate that "this Act will reduce the Federal deficit between 2010 and 2019." Patient Protection and Affordable Care Act § 1563.

5. Barack Obama, President of the U.S., Remarks by the President in State of the Union Address (Jan. 27, 2010) (transcript available at http://www.whitehouse.gov/the-press-office/remarks-president-state-union-address). *See* David M. Mirvis & David E. Bloom, *Population Health and Economic Development in the United States*, 300 JAMA 93, 95 (2008) (finding that improved population health is associated with increased economic growth); Sheila D. Smith et al., *Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?*, 28 HEALTH AFFS. 1276 (2009).

6. *See, e.g.*, Patient Protection and Affordable Care Act § 1003 (authorizing Secretary of the Department of Health and Human Services to review insurance premiums for "unreasonable increases" and to provide grants to states to conduct reviews or rate setting); *id.* § 1103 (limiting Medicare Advantage plans' medical loss ratios to 85% of premiums); *id.* §§ 1311-1331 (creation of health insurance exchanges to offer competitively priced health insurance plans); *id.* § 1421 (small business tax credit for employee health insurance); *id.* § 1561 (standards for electronic enrollment in government programs); *id.* § 2551 (reductions in federal Medicaid funding for disproportionate share hospitals); *id.* § 2601 (grants for demonstrations projects to coordinate care for persons eligible for both Medicare and Medicaid ("dual eligibles")); *id.* § 2602 (improve coordination of benefits for dual eligibles); *id.* § 2701 (authorizing Medicaid waivers to create medical homes to provide cost-effective, coordinated care); *id.* § 2702 (prohibiting Medicaid payments for inappropriate diagnoses); *id.* §§ 2704-2706 (authorizing grants for demonstration projects with Medicaid providers to test bundled payments, global payment systems, and pediatric accountable care organizations); *id.* § 2801 (amending the Medicaid and State Children's Health Insurance Program payment and access provisions); *id.* § 3001 (authorizing value-based purchasing of services for Medicare beneficiaries from hospitals that meet performance standards); *id.* § 3004 (providing that long-term care hospitals that fail to submit reports forfeit Medicare rate increases); *id.* § 3006 (authorizing development of value-based payments by Medicare to skilled nursing facilities, home health agencies, and ambulatory surgical centers); *id.* § 3007 (authorizing adjustments to Medicare payments to physicians based on cost and qual-

majority of health care costs,[7] as well as almost two-thirds of annual deaths in the United States.[8]

Conventional wisdom argues that most chronic diseases are caused by behavioral factors, such as lack of physical activity, poor

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ity of care); *id.* § 3008 (reducing Medicare payments to hospitals for hospital acquired medical conditions); *id.* § 3021 (creating the Center for Medicare and Medicaid Innovation "to test innovative payment and service delivery models to reduce program expenditures"); *id.* § 3022 (authorizing shared savings with Medicare and Medicaid providers who create accountable care organizations that meet quality and cost targets); *id.* § 3023 (authorizing pilot program for bundled Medicare payments); *id.* § 3024 (authorizing demonstration project to test Medicare payment incentive and service delivery models for primary care); *id.* § 3025 (reducing Medicare payments for certain hospital readmissions); *id.* § 3102 (adjusting Medicare physician payment calculations); *id.* §§ 3131-3132 (adjusting Medicare payments for home health care and hospice care); *id.* § 3133 (reducing Medicare payments to disproportionate share hospitals); *id.* § 3134 (providing for review and adjustment of Medicare physician payment claims); *id.* §§ 3135, 3136 (limiting Medicare payments for imaging and powered wheel chairs); *id.* § 3138 (proving for study of cancer hospital costs); *id.* § 3139 (limiting Medicare payments for generic biologics); *id.* § 3140 (authorizing demonstration projects of Medicare hospice program models); *id.* § 3201 (amending Medicare Advantage payment method); *id.* § 3313 (authorizing Inspector General to study prescription drug prices for Medicare Part D covered drugs); *id.* § 3401 (amending market basket bases and adding productivity requirements to Medicare payment calculations); *id.* § 3403 (creating Medicare Payment Advisory Board to "reduce the per capita rate of growth in Medicare spending"); *id.* § 3501 (expanding Agency for Healthcare Research and Quality's authority to conduct research on health care quality, safety and value); *id.* §§ 5001–5701 (including provisions to encourage students to enter primary care, nursing, geriatrics, public health, and allied health professions); *id.* § 6001 (tightening limitations on physician self-referrals); *id.* § 6301 (creating an independent Patient-Centered Outcomes Research Institute to study the effectiveness of medical care); *id.* § 10606 (increasing penalties for health care fraud). *See also*, MATTHEW BUETTGENS ET AL., AMERICA UNDER THE AFFORDABLE CARE ACT 11 (2010), *available at* http://www.urban.org/UploadedPDF/412267-america-under-aca.pdf (estimating savings in the cost of uncompensated care).

7. About 50 million Americans have some kind of disability and about 10 million received Supplemental Security Income (SSI) or Social Security Disability Insurance. *More Than 50 Million Americans Report Some Level of Disability*, U.S. CENSUS BUREAU (May 12, 2006), http://www.census.gov/newsroom/releases/archives/aging_population/cb06-71.html. *See* Kenneth E. Thorpe et al., *Chronic Conditions Account for Rise in Medicare Spending from 1987 to 2006*, 29 HEALTH AFFS. 718 (2010); Catherine Hoffman et al., *Persons with Chronic Conditions: Their Prevalence and Costs*, 276 JAMA 1473, 1476 (1996). *See also* CONG. BUDGET OFFICE, HOW DOES OBESITY IN ADULTS AFFECT SPENDING ON HEALTH CARE? (Sept. 8, 2010), *available at* http://www.cbo.gov/ftpdocs/118xx/doc11810/09-08-Obesity_brief.pdf.

8. Heart disease, cancers, stroke, chronic respiratory diseases, Alzheimer's disease, and diabetes caused 64.5% of deaths in 2009. Kenneth D. Kochanek et al., *Deaths: Preliminary Data for 2009*, 59 NAT'L VITAL STAT. REP. 1, 5, 29 tbl.29 (2011), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_04.pdf. Chronic disease costs may also threaten the global economy. DAVID E. BLOOM ET AL., THE GLOBAL ECONOMIC BURDEN OF NON-COMMUNICABLE DISEASES 35 (2011), *available at* http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf (a report for the World Economic Forum, estimating that heart disease, stroke, cancers, chronic respiratory diseases, diabetes, and mental illness account for 63% of deaths worldwide (72% in high income countries) and could cost a total of $30 trillion worldwide between now and 2030).

diet, and alcohol and tobacco use.[9] It is not surprising, therefore, that policy recommendations to control chronic disease costs emphasize policies to change such behaviors.[10] The ACA follows this trend. Its provisions regulating both public and private insurance include required coverage of preventive care without patient cost sharing and authorization to provide incentives for individuals to participate in wellness programs.[11] While these provisions are generally applauded as promoting good health, their potential for discriminating against people who are overweight, poor, disadvantaged or have chronic ailments has begun to raise concern.[12]

This article examines whether insurance is an appropriate mechanism for improving individual health or reducing the cost of health care for payers, and if so, what principles can guide the design of insurance for either purpose. Insurance is the quintessential tool for spreading and managing risk. However, insurance

9. *See, e.g.*, INST. OF MED., LEADING HEALTH INDICATORS FOR HEALTHY PEOPLE 2020—LETTER REPORT (2011), *available at* http://iom.edu/Reports/2011/Leading-Health-Indicators-for-Healthy-People-2020.aspx; NAT'L CTR. FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION, THE POWER OF PREVENTION: CHRONIC DISEASE . . . THE PUBLIC HEALTH CHALLENGE OF THE 21ST CENTURY (2009), *available at* http://www.cdc.gov/chronicdisease/pdf/2009-Power-of-Prevention.pdf; WORLD HEALTH ORG., GLOBAL STATUS REPORT ON NON-COMMUNICABLE DISEASES 2010 (2011), *available at* http://www.who.int/nmh/publications/ncd_report2010/en/. The seminal work identifying behavioral risk factors as the underlying cause of many diseases is J. Michael McGinnis & William F. Foege, *Actual Causes of Death in the United States*, 270 JAMA 2207 (1993).

10. *See, e.g.*, CTRS. FOR DISEASE CONTROL & PREVENTION, NAT'L CTR. FOR CHRONIC DISEASE PREVENTION & HEALTH PROMOTION, AT A GLANCE 2010: HEALTH RISKS IN THE UNITED STATES: BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM, *available at* http://www.cdc.gov/chronicdisease/resources/publications/AAG/brfss.htm; NAT'L CTR. FOR HEALTH STATISTICS, CTRS. FOR DISEASE CONTROL AND PREVENTION, HEALTHY PEOPLE 2010 FINAL REVIEW LHI-3-9 (2011), *available at* http://www.cdc.gov/nchs/data/hpdata2010/hp2010_final_review.pdf (reporting that the top 10 "leading health indicators" were physical activity, nutrition and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care). *But see Leading Health Indicators: 2020 LHI Topics*, HEALTHY PEOPLE.GOV, http://www.healthypeople.gov/2020/LHI/2020indicators.aspx (last updated Jan. 25, 2012) (reversing the order of many indicators to lead with access to health care, clinical preventive services, and environmental quality).

11. *See infra* Part III.

12. *See, e.g.*, Jennifer Bard, *When Public Health and Genetic Privacy Collide: Positive and Normative Theories Explaining How ACA's Expansion of Corporate Wellness Programs Conflicts with GINA's Privacy Rules*, 39 J.L. MED. & ETHICS 469 (2011); Nurit Guttmann, *On Being Responsible: Ethical Issues in Appeals to Personal Responsibility in Health Campaigns*, 6 J. HEALTH COMM. 117 (2010); Kristin M. Madison et al., *The Law, Policy, and Ethics of Employers' Use of Financial Incentives to Improve Health*, 39 J.L. MED. & ETHICS 450 (2011); Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 CONN. INS. L.J. 199 (2008); Mark A. Rothstein & Heather L. Harrell, *Health Risk Reduction Programs in Employer-Sponsored Health Plans: Part II—Law and Ethics*, 51 J. OCCUPATIONAL & ENVTL MED. 951 (2009); Robert Steinbrook, *Imposing Personal Responsibility for Health*, 355 NEW ENG. J. MED. 753, 753 (2006).

risk management targets financial losses or costs; it is not typically designed to improve the policyholder's physical or mental wellbeing (beyond the presumed "peace of mind" of having insurance).[13] At the same time, insurance does play a significant role in shaping public attitudes toward responsibility for health risks,[14] as described in Part II. I argue that, by establishing a new, seemingly universal design for the medical care that society should make available and what individuals should do to protect their own health, the ACA contains implicit standards for the allocation of responsibility for health. Part III briefly describes the ACA's provisions governing preventive care coverage and wellness programs that suggest these implicit standards. In practice, wellness programs typically seek to change a limited set of personal traits, like obesity, or behaviors, like smoking. Thus, Part IV summarizes the evidence of the effects of preventive care and employee wellness programs, which suggest somewhat more success in making people feel better than in reducing costs.

Because insurance provides the financial foundation for so many institutions in the national economy, Part V explores how the ACA's use of insurance to encourage personal responsibility for risk prevention may influence social attitudes and policies about conditions of employment, housing, and social relationships. A different approach, using community-based programs instead of insurance-based wellness programs, is discussed in Part V. I conclude, in Part VI, that health promotion should be encouraged, because health is valuable for its own sake. Insurance, however, is poorly suited to improve health or manage behavioral risks to health. Rather, it operates best as a mechanism for financing access to preventive care without cost-sharing. Although insurance can determine actuarially fair premiums, its tools are too crude to attribute to specific behaviors the health care costs of chronic conditions with complex causes. Characterizing ill health as the product of individual choice—an individual responsibility—poses credible risks to the legal rights and economic conditions of many disadvantaged populations in the United States. Wellness programs that reward good health or penalize unhealthy behaviors are likely to shape public perceptions of individual social worth

13. *See* Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395, 1401, 1405 (1994).

14. Mariner, *supra* note 12; SMOKING POLICY: LAW, POLITICS & CULTURE 6, 185-88 (Robert L. Rabin & Stephen D. Sugarman, eds., 1993).

and justify abusive practices, such as denying employment, on the pretext of improving public health. If such programs are to offer the benefits of improved health without marginalizing a growing population, the laws governing health insurance plans should not permit individual financial rewards or penalties for wellness program participation. Instead, such programs should be offered independently of insurance.

II. INSURANCE REFLECTS AND SHAPES CONCEPTIONS OF RESPONSIBILITY FOR RISK

Insurance underpins most of the American—indeed the global—economy, making it possible for businesses to operate normally as well as to take entrepreneurial risks.[15] Few businesses can operate without several types of insurance, including general liability, directors' liability, and casualty insurance. By setting conditions on issuing such policies and requiring the performance of other conditions after issuance, insurers influence financial and commercial behavior. Like most insurers, health insurers often obtain reinsurance and design their policies to meet the requirements of the reinsurer.[16] Even common personal and social activities, such as buying a motor vehicle and obtaining a home mortgage, require the purchase of insurance as a condition precedent. Jeffrey Stempel summarizes the breadth and depth of this influence, concluding that "[i]nsurance policies serve a function in the social ordering of personal and economic activity. . . . [T]hey serve as part of the infrastructure by which such activity is conducted." [17]

The influence of insurance is beginning to be seen as a form of governance itself.[18] National social welfare systems for pensions, unemployment compensation, and health care operate as insurance systems and may use private insurers to administer costs

15. For histories of insurance, see JOHN A. BOGARDUS, JR., SPREADING THE RISKS: INSURING THE AMERICAN EXPERIENCE (2003) and ANDREW TOBIAS, THE INVISIBLE BANKERS (1992).

16. Reinsurance is insurance for insurers. Insurance companies transfer some of the risk they assumed from policyholders to a reinsurance company. ROBERT H. JERRY II, UNDERSTANDING INSURANCE LAW, § 140a, 1015 (4th ed. 2007); Aviva Abramovsky, *Reinsurance: The Silent Regulator?*, 15 CONN. INS. L.J. 345, 350 (2009).

17. Jeffrey W. Stempel, *The Insurance Policy as Social Instrument and Social Institution*, 51 WM. & MARY L. REV. 1489, 1497 (2010).

18. RICHARD V. ERICSON ET AL., INSURANCE AS GOVERNANCE 45 (2003) (initiating sociological research on insurance as an institution of governance by private entities and describing the results of the empirical study).

and claims.[19] Of course, governments also authorize, by licensing, private insurers to directly underwrite specific risks, such as workers compensation and health benefit plans. Increasingly, however, governments rely on private insurance companies to provide the financial security needed for commercial businesses to operate,[20] a way of managing risks that could be considered the function of governments. The insurance policy requirements serve to partially govern commercial operations and policyholders' conduct,[21] lessening the need for formal legal rules, but performing a similar function and without public accountability.

Insurance governs from behind the scene. In the background, its influence can be invisible or taken for granted. Yet the content of insurance policies shapes public opinion about acceptable risks and appropriate responses to risks.[22] One way in which this happens is by the standardization of insurance terms.[23] Most health insurance policies are standard form contracts.[24] Standard form contracts have characteristics analogous to standardized product specifications.[25] Coverage choices—which risks are covered or excluded—that are standard features of insurance policies begin to look like essential elements of an acceptable product, just as having seatbelts in automobiles were regarded first as acceptable,

19. *See* THE EVOLUTION OF SOCIAL INSURANCE 1881-1981 (Peter A. Kohler & Hans F. Zacher eds., 1982). Medicare, for example, contracts with private insurers to administer Medicare benefits. *Processing of Claims for Part A and Part B: Enterprise Architecture*, CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., 1-1 (2006), *available at* www.cms.gov/MedicareContractingReform/downloads/ProcessingClaimsforPartA&BEnterpriseArchitecture.pdf.

20. ERICSON ET AL., *supra* note 18, at 45.

21. Friedrich Kessler, *Contracts of Adhesion—Some Thoughts about Freedom of Contract*, 43 COLUM. L. REV. 629, 631 (1943) (describing how "standard clauses in insurance policies" enable insurers to "select and control risks assumed under a contract").

22. *See generally* PAUL SLOVIC, THE PERCEPTION OF RISK (2000) (describing approaches to risk perception).

23. W. David Slawson, *Standard Form Contracts and Democratic Control of Lawmaking Power*, 84 HARV. L. REV. 529, 531 (1971) (noting that almost all contracts used standard forms and provisions).

24. Wendy K. Mariner, *Standards of Care and Standard Form Contracts: Distinguishing Patient Rights and Consumer Rights in Managed Care*, 15 J. CONTEMP. HEALTH L. & POL'Y 1, 34, 37 (1998) (arguing that most health insurance contracts should be interpreted as standard form contracts issued without bargaining on the part of the individual policyholder); Susan Randall, *Freedom of Contract in Insurance*, 14 CONN. INS. L.J. 107, 108 (2007) (critiquing the emphasis on interpreting text in insurance policies).

25. Although most lawyers classify insurance policies as contracts, the health insurance industry refers to insurance policies as "products." Products can be regulated to protect consumers from hidden hazards. *See* Jeffrey W. Stempel, *The Insurance Policy as Thing*, 44 TORT TRIAL & INS. PRAC. L.J. 813, 831 (2009); Daniel Schwarcz, *A Products Liability Theory for the Judicial Regulation of Insurance Policies*, 48 WM. & MARY L. REV. 1389, 1395 (2007).

then as a necessary feature. When particular product specifications become standard features, they can create an expectation and a social norm. Similarly, when specific medical conditions are excluded from coverage or covered only at a higher premium, such conditions appear to be outside the norm.

Insurance can "govern" behavior by establishing norms of conduct.[26] The norm in insurance is constructed on the basis of empirical estimates of the distribution of risk in a population, not a social ideal.[27] The statistical mean is merely descriptive of a population. People with a risk profile near the mean are normal. However, such statistical data can be seen in moral terms, where normal acquires a moral meaning. People with a risk profile at either extreme of the curve can be seen as outliers or even pathological.[28] Ian Hacking argues that awareness of risk data has "looping effects," in which the knowledge of what is statistically normal creates pressure to be normal, narrowing the scope of normal and widening the range of the abnormal or excessively risky.[29] This suggests that people may assign normative values or moral weight to risk probabilities.[30] Moral judgments are easily hidden in the probabilistic language of risk, because probabilities appear to be objective.

More than any other industry, insurance depends on quantifying the probability of an unwanted occurrence and the probable harm produced if it occurs. Insurance thus appears to transform danger into a manageable risk calculation.[31] A manageable risk appears to be subject to human control. Thus, those with higher risks can be seen as failing to prevent their own problems; they can be seen as out of control.[32] For example, studies on the causes of car accidents led to changing the name from accident to motor

26. Deborah Stone, *Beyond Moral Hazard: Insurance as a Moral Opportunity*, 6 CONN. INS. L.J. 11, 46 (1999-2000).

27. ERICSON ET AL., *supra* note 18, at 68-69.

28. IAN HACKING, THE TAMING OF CHANCE 2 (1990).

29. *Id.*

30. *See* PAUL SLOVIC, THE FEELING OF RISK: NEW PERSPECTIVES ON RISK PERCEPTION (2011) (discussing various ways in which cultural factors influence perceptions of risk).

31. *But see* PETER L. BERNSTEIN, AGAINST THE GODS: THE REMARKABLE STORY OF RISK (1998); RICHARD V. ERICSON & AARON DOYLE, UNCERTAIN BUSINESS: RISK, INSURANCE, AND THE LIMITS OF KNOWLEDGE (2004) (describing the uncertainty of actuarial risk estimates).

32. For arguments that the literature on risk portrays an increasing number of risks as being under human control and, therefore, that the responsibility for avoiding the ensuing harms should belong to the individual, see JOHN ADAMS, RISK (1995) and JAMES REASON, HUMAN ERROR (1990).

vehicle crashes, to emphasize the responsibility of drivers or vehicle design for safety.[33]

Insurance, then, is not only a way to manage the financial cost of risks; it also allocates responsibility for risks.[34] Responsibility is often thought of as falling into two categories: personal responsibility and collective responsibility—which can include broad, social or governmental responsibility and smaller, private group or community responsibility.[35] As a form of mutual aid and collective responsibility, insurance influences how people perceive risks.[36] If insurance is not available for a risk, like hurricane coverage in coastal Florida or investigational drugs, it suggests that the risk is too great or too uncertain to spread in any fair way. Those who choose to live in that zone or participate in research should understand that they are on their own if disaster strikes. If insurance is easily available, it might suggest that the risk is small or that it is so common that it can be easily spread. Such risks may appear normal, if not enticing. In this way, as Deborah Stone writes, insurance serves to identify risks that are seen as "amenable to human agency and collective action."[37] Thus, decisions about what risks to cover embody implicit normative judgments about what risks should be shared or remedied together. Covered risks are seen as a collective responsibility, while excluded risks remain the personal responsibility of individuals.

Whether insurance is sited in the public or private sector offers another clue as to whether the risks it covers are viewed as a social responsibility or a personal one. Government-required social insurance systems like Social Security and unemployment insurance reflect the idea that society should protect people from destitution in old age or lack of work.[38] The fact that life insurance re-

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33. Ericson et al., *supra* note 18, at 270.

34. Tom Baker, *Risk, Insurance, and the Social Construction of Responsibility*, *in* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 33 (Tom Baker & Jonathan Simon eds., 2002).

35. *Id.*; Mariner, *supra* note 12, at 205-07.

36. Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287, 279, 314 (1993). *See* MARY DOUGLAS, RISK AND BLAME: ESSAYS IN CULTURAL THEORY (1990).

37. Deborah Stone, *Beyond Moral Hazard*, *in* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 54 (Tom Baker & Jonathan Simon eds., 2002).

38. Perhaps the best known arguments over social insurance are contained in Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963) (generally for) and Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531 (1968) (generally against).

mains available only from private commercial companies suggests that it is an option for individuals and, therefore, only a personal responsibility.[39] The ACA's minimum coverage requirement moves health insurance in the United States away from the personal responsibility model and much closer to a social insurance model.[40] In European countries with social insurance systems, the introduction of competitive market reforms has sometimes raised concerns that such reforms dilute the culture of solidarity.[41]

As everyone knows, health insurance spreads risk by pooling premium revenues from all individuals in a group to pay for losses incurred—medical care obtained—by individuals in the group.[42] In effect, the healthy—those who incur few or no costs—subsidize the group members who do get care that is covered by the health insurance plan. Few insurers, or policyholders for that matter, speak of a group insurance plan as a subsidy to the ill or unhealthy.[43] Rather, this form of subsidy appears to be accepted as quite normal by those who buy the coverage, suggesting that buyers consider the covered risks to be matters for collective action. On the other hand, policyholders often seek to join the lowest risk (and least expensive) group, thereby disaggregating the sphere of collective action into smaller groups.[44] Insurers in an unregulated, voluntary market segment the market by classifying risks into smaller groups.[45] Thus, the strength of the spirit of solidarity may depend on the price of insurance and the degree to which people prefer not to be classified as a high risk. Risk classification itself

39. Histories of commercial life insurance in the United States suggest that it gained consumer acceptance when characterized as a way for individuals to take responsibility for providing for their families in the event the breadwinner died. *See, e.g.*, VIVIANA A. ROTMAN ZELIZER, MORALS AND MARKETS: THE DEVELOPMENT OF LIFE INSURANCE IN THE UNITED STATES (1979); Brian J. Glenn, *God and the Red Umbrella: The Place of Values in the Creation of Institutions of Mutual Assistance*, 10 CONN. INS. L.J. 277 (2004).

40. Wendy K. Mariner, *Health Reform: What's Insurance Got to Do with It? Recognizing Health Insurance as a Separate Species of Insurance*, 36 AM. J.L. & MED. 436, 438 (2010).

41. *See, e.g.*, Karl Hinrichs, *The Impact of German Health Insurance Reforms on Redistribution and the Culture of Solidarity*, 20 J. HEALTH POL. POL'Y & L. 653 (1995); Hans Maarse & Aggie Paulus, *Has Solidarity Survived? A Comparative Analysis of the Effect of Social Health Insurance Reform in Four European Countries*, 28 J. HEALTH POL. POL'Y & L. 585 (2003).

42. *See generally* KENNETH S ABRAHAM, INSURANCE LAW AND REGULATION (2d ed. 1995); JERRY II, *supra* note 16.

43. Stone, *supra* note 36, at 292.

44. Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 662 (2008).

45. Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371, 377 (2003).

may influence perceptions of responsibility for risk by encouraging segregation into economically favored and disfavored groups.

The ACA is legislation that may shift Americans' conception of health insurance, but insurance can also influence law. For example, Kenneth Abraham argues persuasively that the availability of liability insurance enabled tort liability claims that would have been uncollectable in the absence of insurance.[46] A common complaint among some economists is that insurance distorts the market for health care, encouraging excessive use of services and rising prices by removing the buyer's awareness of the cost of care.[47] This complaint may have limited application to medical services, however, because physicians, not patients, make the major decisions about what kind of care a patient should receive. And, sick patients are unlikely to "shop around" for the cheapest hospital, whether or not they have insurance.

Nevertheless, health insurance may influence public policy by suggesting that the services that are covered are a social responsibility, while those that are excluded or subject to cost-sharing are matters of personal choice. Social policy has influenced health insurance by requiring health insurers to cover many preventive services that would not ordinarily be covered in a conventional indemnity insurance policy.[48] Such coverage is intended to encourage individuals to get the preventive services that they might not otherwise get, often because of cost, with the expectation that those services may help to prevent future illness.[49] Although property and casualty insurers sometimes require their policyholders to keep their property reasonably maintained as a condition of coverage, health insurers have not required individuals to stay healthy as a condition of continued health insurance coverage. Of course, until some state laws and now the ACA required guaranteed issue, insurers did not have to sell a policy to anyone with a preexisting condition or, alternatively, could exclude cover-

46. KENNETH S. ABRAHAM, THE LIABILITY CENTURY: INSURANCE AND TORT LAW FROM THE PROGRESSIVE ERA TO 9/11 (2008). *See also* Tom Baker, *Liability Insurance as Tort Regulation: Six Ways That Liability Insurance Shapes Tort Law in Action*, 12 CONN. INS. L.J. 1 (2005).

47. *See generally* Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963); W. Henry Chiu, *Health Insurance and the Welfare of Health Care Consumers*, 64 J. PUB. ECON. 125 (1996); Martin S. Feldstein, *The Rising Price of Physicians' Services*, 52 REV. ECON. & STAT. 121 (1970); Martin S. Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 J. POL. ECON. 251 (1973).

48. Mariner, *supra* note 40, at 445.

49. *Id.*

age of preexisting conditions.[50] With the ACA's new requirements, the question is whether health insurers and employers can require policyholders to "maintain" their bodies in the same way that other insurers require automobile owners to perform regular car maintenance.

III. ACA INSURANCE PROVISIONS TO PROMOTE HEALTH

The ACA has three different approaches to promoting health: (1) encouraging and funding government and community research, education, and projects to improve health and provide health-promoting conditions;[51] (2) requiring coverage of preventive health services in public and private health insurance programs;[52] and (3) authorizing both state Medicaid plans and private health insurance plans, including those sponsored by employers, to offer wellness programs.[53] The first two approaches are not controversial, because they offer benefits to all, without requiring participation

50. 42 U.S.C. § 300gg-1 (requiring guaranteed issue); § 300gg-2 (prohibiting preexisting condition exclusions).

51. Title IV of the ACA, "Prevention of Chronic Disease and Improving Public Health," is one of nine substantive titles. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 4001-4306, 124 Stat. 119, 538-587 (2010) (codified in scattered sections of 29 and 42 U.S.C.). Most of the sections in this title authorize federal funding for preventive health services, *id.* § 4101, 124 Stat. at 546 (codified at 42 U.S.C. § 280h-4 to -5) (grants to operate school health centers), education, *id.* § 4102, 124 Stat. at 550 (codified at 42 U.S.C. § 280k-3) (creating an educational campaign for oral healthcare prevention and grants for research on dental caries prevention), and outreach, *id.* § 4004, 124 Stat. at 544 (codified at 42 U.S.C. § 300u-12) (creating an education and outreach program to "encourage[] healthy behaviors linked to the prevention of chronic diseases"). A "Prevention and Public Health Fund" was established to pay for many of these programs. *Id.* § 4002, 124 Stat. at 541 (codified at 42 U.S.C. § 300u-11). The Fund, originally enacted to receive $15 billion over ten years ($5 billion in its first five years), may suffer from deficit budget-cutting. *Id.* The President has already proposed reducing the fund by $3.5 billion. OFFICE OF MGMT. & BUDGET, EXEC. OFFICE OF THE PRESIDENT, LIVING WITHIN OUR MEANS AND INVESTING IN THE FUTURE: THE PRESIDENT'S PLAN FOR ECONOMIC GROWTH AND DEFICIT REDUCTION (2011), *available at* http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf.

52. Patient Protection and Affordable Care Act § 1001, 124 Stat. at 1301 (codified at 42 U.S.C. § 300gg-13) (private coverage of preventive services); *id.* § 4103, 124 Stat. at 553 (codified at 42 U.S.C. § 1395x(s)(2)) (Medicare coverage of annual wellness visit without cost sharing); *id.* § 4104, 124 Stat. at 557 (codified at 42 U.S.C. § 1395x) (Medicare coverage of preventive services recommended by the U.S. Preventive Services Task Force); *id.* § 4106, 124 Stat. at 559 (Medicaid coverage of preventive services for adults); *id.* § 4107, 124 Stat. at 560 (to be codified at 42 U.S.C. § 1396(d)) (coverage of tobacco cessation services for pregnant Medicaid beneficiaries). An independent Preventive Services Task Force, affiliated with the Agency for Healthcare Research and Quality, was created to review and recommend clinical preventive services for coverage. *Id.* § 4003(a), 124 Stat. at 541 (codified at 42 U.S.C. § 299b-4). For services covered, see *Recommendations*, U.S. Preventive Services Task Force, www.uspreventiveservicestaskforce.org/recommendations.htm.

53. 42 U.S.C. §§ 1396a, 300gg-4. *See infra* text accompanying notes 57-110.

or imposing financial penalties on non-participation.[54] In contrast, the third approach allows employers and insurers to hold non-participating or unsuccessful plan enrollees responsible for a larger share of costs than other enrollees. These provisions use insurance to try to reduce individual health risks. Although the ACA's insurance regulation provisions generally eliminate risk segmentation within insurance pools, for example, by requiring guaranteed issue and coverage of preexisting conditions,[55] the wellness program provisions reintroduce some risk segmentation into the plan's pool of enrollees.[56] This element has the potential to reshape laws governing discrimination, particularly in employment.

The ACA's encouragement of wellness programs expands an exception to the prohibition against discrimination among group health plan enrollees in the Health Insurance Portability and Accountability Act ("HIPAA").[57] Although that section prohibited group health insurance plans from discriminating with respect to premiums or eligibility or benefits on the basis of "health factors,"[58] it allowed plans to offer premium discounts or rebates or modify cost-sharing for "adherence to programs of health promotion and disease prevention."[59] Regulations adopted in 2006 fleshed out the types of programs that qualified for the exception.[60]

The ACA's version of this provision expands this exception by allowing insurers to offer wellness programs in both the individual

54. *See* § 4003(b) (codified at 42 U.S.C. § 280g-10) (creating a separate Community Preventive Services Task Force, convened by the Centers for Disease Control and Prevention, to review population-based services).

55. § 1201, 124 Stat. at 154 (codified at 42 U.S.C. § 300gg-1) (guaranteed issue); *id.* (codified at 42 U.S.C. § 300gg-2) (guaranteed renewability); *id.* (codified at 42 U.S.C. § 300gg-3) (prohibition against preexisting condition exclusions); § 1001, 124 Stat. at 130 (codified at 42 U.S.C. § 300gg-11) (prohibition on lifetime and annual limits); *id.* (codified at 42 U.S.C. § 300gg-12) (prohibition on rescission). *See* Mariner, *supra* note 12, at 222 (describing how wellness programs can reintroduce risk rating into the pool of insureds).

56. Mariner, *supra* note 12, at 222.

57. § 1201, 124 Stat. at 154 (codified at 42 U.S.C. § 300gg-4). The original provision is also included in the Employee Retirement Income Security Act, 29 U.S.C. § 1182 (2010) and the Internal Revenue Code, 26 U.S.C. § 9802 (2006).

58. 42 U.S.C. § 300gg-4 (Supp. III 2009). Health factors were defined to include: "health status; medical condition (including both physical and mental illnesses); claims experience; receipt of health care; medical history; genetic information; evidence of insurability (including conditions arising out of acts of violence); and disability. *Id.* The ACA changed the term "health factor" to "health status-related factors" and added "any other health status-related factor determined appropriate by the Secretary of Health and Human Services" to the definition. 42 U.S.C. § 300gg-4 (2012).

59. *Id.*; 29 U.S.C. § 1182(b)(2)(B).

60. 29 C.F.R. § 2590.702(f) (2011); 42 C.F.R. § 54.9802-1 (2011); 45 C.F.R. § 146.121(f) (2011). *See* Mariner, *supra* note 12, at 219 (describing the 2006 regulations).

and group market.[61] It also incorporates the requirements of the 2006 regulations into a new subsection (j), which divides wellness programs into those that can be offered freely and those that must meet additional requirements to be considered non-discriminatory.[62] Several of the five categories of wellness programs that do not have to meet additional requirements appear to offer beneficial services.[63] These include programs that pay for all or part of membership in a fitness center or smoking cessation programs or that offer a reward for attending periodic health education seminars.[64] They also include a "program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under a group health plan for the cost of certain items or services related to a health condition (such as prenatal care or well-baby visits)."[65] This could be a welcome benefit in grandfathered, employer-sponsored group health plans that do not waive cost-sharing for preventive services. It is possible, of course, that individuals who are encouraged to use these services could perceive the attention as singling them out for their unfavorable health conditions. Employee reactions may depend on whether all employees, including individuals who are quite fit, are encouraged to attend health education programs and whether their employers track attendance.

The last wellness program in the exempt list is one that rewards individuals for participating in a diagnostic testing program, as long as it does not base the reward on an individual's test outcomes.[66] This seems intended to encourage people to identify any health problems they have, so that they can take appropriate action. Here again, however, if the test results are tracked by employers, employees may fear other forms of employment discrimination, either because of a discovered health problem or an individual's failure to treat it. Commercial companies that sell wellness programs to insurers and employers often emphasize the importance of screening employees for health conditions in order to permit personalized health promotion and disease management

61. 42 U.S.C. § 300gg-4(a).
62. *Id.* § 300gg-4(j).
63. *Id.* § 300gg-4(j)(2).
64. *Id.*
65. *Id.* § 300gg-4(j)(2)(C).
66. 42 U.S.C. § 300gg-4(j)(2)(B).

plans.[67] Thus, a testing program is often the beginning of more targeted incentives directed at individual employees.

The second category of permissible programs can offer rewards and penalties based on a person's health status as long as they meet four relatively simple requirements.[68] First, the program must be "reasonably designed to promote health or prevent disease."[69] However, the program also must not be "overly burdensome" or "a subterfuge for discriminating based on a health status factor."[70] Despite this appropriately cautionary language, it should be relatively easy to justify programs aimed at behaviors that are generally believed to increase the risk of chronic diseases in large populations. Second, the reward opportunity must be offered annually, which is a very simple condition to meet.[71]

Third, the reward opportunity must be available to all similarly situated individuals, which generally means everyone in the insurance pool or worksite, which is a seemingly simple requirement.[72] However, a reward is not considered to be available to all if some individuals cannot meet the reward requirements, such as lowered cholesterol or weight loss.[73] To retain the exempt status of the program, it must offer an alternative standard to be met by individuals who find it "unreasonably difficult due to a medical condition" to meet the regular standard or for whom it would be "medically inadvisable to attempt to satisfy"[74] the regular standard. This appears to be a solicitous addition. However, the provision notes that the plan "may seek verification [of the medical difficulties] from an individual's physician."[75] The 2006 regulations, which appear to serve as the template for these statutory sections, offer examples of "alternative standards" in such cases, which include following the advice of the individual's physician, such as taking medication and getting blood tests.[76] Thus, it would be permissible for a plan to require a person to follow a physician's recommendations in order to qualify for any reward.

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67. HA T. TU & RALPH C. MAYRELL, EMPLOYER WELLNESS INITIATIVES GROW, BUT EFFECTIVENESS VARIES WIDELY 2 (2010), *available at* http://www.nihcr.org/Employer-Wellness-Programs.pdf.

68. 42 U.S.C. § 300gg-4(j)(3).

69. *Id.* § 300gg-4(j)(3)(B).

70. *Id.*

71. *Id.* § 300gg-4(j)(3)(C).

72. *Id*. § 300gg-4(j)(3)(D).

73. 42 U.S.C. § 300gg-4(j)(3)(D)(i).

74. *Id.* § 300gg-4(j)(3)(D)(i)(I), (II).

75. *Id.* § 300gg-4(j)(3)(D)(ii).

76. 29 C.F.R. § 2590.702(f)(3)(ex. 3), (ex. 4).

The fourth requirement limits the amount of any reward to 30% of an individual's total premium, including both the employer and employee contributions.[77] This represents an increase from the 20% limit in the 2006 regulations.[78] The reward can be in the form of a premium discount, a waiver of cost-sharing, or the absence of a surcharge.[79] In other words, the reward can function as a penalty for those who do not receive it.[80] In 2010, the average annual premium for employer-sponsored group health insurance for individual coverage was $5,049,[81] which could allow an additional payment of $1,515 for non-participants or unsuccessful participants. If the employee's family is eligible to participate in a wellness program, the additional payment could apply to the price of family coverage, which averaged $13,770 in 2010. Premiums for independently purchased health insurance, such as policies purchased through a future health insurance exchange, generally are higher than employer-sponsored plan premiums, so that wellness program rewards and penalty payments under such policies could be correspondingly larger. Moreover, the ACA authorizes the Secretaries of Labor, Health and Human Services, and the Treasury to increase the maximum additional payments to 50% of the total cost of premiums "if the Secretaries determine that such an increase is appropriate."[82] If the Secretaries base their determination on the somewhat optimistic literature on wellness programs, an increase is likely.[83]

Health insurers and group health plans are to report annually to the Secretary on the results of wellness programs, as well as other quality measures, such as medication and care compliance initiatives, and activities to prevent hospital readmission, improve patient safety, and reduce medical errors.[84] The wellness programs are permitted to include smoking cessation, weight management, physical fitness, nutrition, health disease prevention,

77. 42 U.S.C. § 300gg-4(j)(3)(A).

78. 29 C.F.R. § 2590.702(f)(3)(ex. 1)(ii); 42 C.F.R. §54.9802-1(f) (2011); 45 C.F.R. § 146.121(f)(3)(ex. 1)(ii) (2011).

79. 42 U.S.C. § 300-4(j)(3)(A).

80. *See* 45 C.F.R. § 146.121(f)(3)(ex. 2)(i), (ex. 5)(i)-(ii).

81. Gary Claxton et al., *Health Benefits in 2010: Premiums Rise Modestly, Workers Pay More Toward Coverage*, 29 HEALTH AFFS. 1942, 1943 (2010).

82. 42 U.S.C. § 300gg-4(j)(3)(A).

83. *See infra* Part IV.

84. 42 U.S.C. § 300gg-17 (2010). For a discussion of the patient safety provisions, *see generally* Barry R. Furrow, *Regulating Patient Safety: The Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1727 (2011).

healthy lifestyle support, and diabetes prevention.[85] However, they are not allowed to collect information about or deny discounts on the basis of lawful possession of firearms.[86]

The ACA also authorizes federal grants to state Medicaid programs to "provide incentives to Medicaid beneficiaries who 'successfully participate' in wellness programs and 'demonstrate changes in health risk and outcome, including the adoption and maintenance of healthy behaviors by meeting specific targets.'"[87] The eligible programs are those that succeed in one or more of the following: (1) ceasing use of tobacco; (2) controlling or reducing weight; (3) lowering cholesterol; (4) lowering blood pressure; and (5) avoiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition.[88] States are required to track and validate beneficiary progress, as well as evaluate the program's effectiveness.[89] What counts as a permissible incentive is not specified in the Act. If the programs must "validate" beneficiary progress, however, states may try to use more coercive incentives than would be permitted in private health plans.[90]

The ACA encourages experimentation with wellness programs in other ways.[91] The Departments of Health and Human Services, Treasury, and Labor are to create demonstration projects for ten states to have health insurers implement wellness programs that comply with the above ACA requirements.[92] The programs are not to decrease insurance coverage or trigger additional federal tax credits or subsidies for people to obtain health coverage.[93] The Secretaries are to report to Congress on whether such programs are effective in "promoting health and preventing disease," their impact on "access to care and affordability of coverage," their ef-

85. 42 U.S.C. § 300gg-17(b).

86. *Id.* § 300gg-17(c).

87. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4108(a)(1)(i), (ii), 124 Stat. 119, 561 (2010).

88. *Id.* § 4108(a)(3)(A)(i)-(v), 124 Stat. at 561.

89. *Id.* § 4108(c)(1), 124 Stat. at 562.

90. Prior to the ACA's enactment, several states (Florida, Idaho, Kentucky, West Virginia, Wisconsin, and Wyoming) obtained Medicaid waivers to begin wellness programs. *See* JESSICA GREENE, MEDICAID EFFORTS TO INCENTIVIZE HEALTHY BEHAVIORS 8-9 (2007), *available at* http://www.chcs.org/usr_doc/Medicaid_Efforts_to_Incentivize_Healthy_Behaviors.pdf.

91. Patient Protection and Affordable Care Act § 4206, 124 Stat. at 576 (demonstration project concerning individualized wellness plan); § 4303, 124 Stat. at 582 (codified at 280*l* to -3) (CDC and employer-based wellness programs). *See* Howard K. Koh & Kathleen G. Sebelius, *Promoting Prevention Through the Affordable Care Act*, 363 NEW ENG. J. MED. 1296 (2010).

92. 42 U.S.C. § 300gg-4(*l*) (2010).

93. 26 U.S.C. § 36B (2010) (tax credits); 42 U.S.C. § 18071 (subsidies).

fect on "changing behavior," and the "effectiveness of different types of rewards."[94] The requirement to analyze the effects of wellness programs is welcome. However, one might ask what would happen if the analysis found either that major health improvements substantially increased costs or that significant cost savings failed to noticeably prevent disease.

Because large employers are more likely to be able to offer both health insurance and wellness programs, the Act provides grants for small employers to provide wellness programs[95] and funds the CDC to allow it to provide technical assistance.[96] Group health plan premiums are community rated, so that all members of the group pay the same amount, regardless of their individual health risks. Although the ACA limits and smooths insurance premium rates for qualified plans offered in health insurance exchanges,[97] it permits higher premium rates to account for geographic area, age, and smoking.[98] Rates for tobacco use cannot be more than 1.5 times the standard premium.[99] In effect, however, the use of wellness programs could create a special rate band of between 130 and 150% of the group rate for persons who fail to participate in wellness programs or meet health standards.[100] For persons who fail to stop using tobacco products, a wellness program penalty, together with a permitted rate differential, could increase their health insurance premiums to 180% of the group premium (200% if the wellness program penalty is increased to 50% in the future). Thus, a $5,000 annual premium could rise as high as $9,000.

The emphasis on health promotion is evident throughout the Act. The Act creates a National Prevention, Health Promotion, and Public Health Council, chaired by the Surgeon General, within the Department of Health and Human Services, to make "recommendations to the President and Congress concerning the most pressing health issues confronting the United States and changes in Federal policy to achieve national wellness, health promotion,

94. 42 U.S.C. § 300gg-4(m).

95. *Id.* § 280*l*-1 (note).

96. *Id.* § 280*l*.

97. The Act imposes minimum medical loss ratios, 42 U.S.C. § 18051(b)(3), risk corridors, *id.* § 18062, allows risk adjustments, *id.* § 18063, and requires reinsurance for "high-risk" enrollees in individual plans offered in health insurance exchanges, *id.* § 18061. Between 50 and 100 "high-risk" conditions or diagnoses are to be identified. *Id*.

98. 42 U.S.C. § 300gg(a)(1). Rates for older adults cannot be more than three times the standard premium. *Id.* Rate can also vary for individual versus family coverage. *Id*.

99. *Id.*

100. *See* text accompanying notes 76-81.

and public health goals, including the reduction of tobacco use, sedentary behavior, and poor nutrition."[101] The Council issued its first "National Prevention and Health Promotion Strategy" on June 22, 2011.[102] This report properly recognizes the effects of social determinants on health:

> Many of the strongest predictors of health and well-being fall outside of the health care setting. Social, economic, and environmental factors all influence health. People with a quality education, stable employment, safe homes and neighborhoods, and access to high quality preventive services tend to be healthier throughout their lives and live longer.[103]

Although the Report encourages social and environmental improvements, it does not recommend specific programs, beyond education, to carry them out.[104] Structural changes in agricultural policy, roadways, transportation, and the built environment would require new legislation, which would require substantial financial resources and could face political opposition.[105]

The Report's most specific recommendations—its seven priorities—focus on personal behaviors: tobacco free living; preventing drug abuse and excessive alcohol use; healthy eating; active living; injury and violence free living; reproductive and sexual health; and mental and emotional well-being.[106] In particular, it encourages payers, including public health benefit programs and commercial health insurers, as well as employers, to provide wellness programs.[107]

No matter how understandable the focus on personal behaviors is, it may miss an opportunity to significantly reduce the personal burden of chronic disease in the country. The reasons for the high cost of chronic care are multifaceted. People with chronic diseases typically need ongoing treatment, but many have no consistent

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101. *Id.* § 300u-10.

102. NAT'L PREVENTION COUNCIL, NATIONAL PREVENTION STRATEGY: AMERICA'S PLAN FOR BETTER HEALTH AND WELLNESS (2011), *available at* http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf.

103. *Id.* at 6. It also notes the importance of threats to health from what it calls "community stressors (e.g., job and home losses, discrimination, family separations, and violence)." *Id.* at 11.

104. *Id.*

105. *See* Fazal Khan, *Combating Obesity through the Built Environment: Is There a Clear Path to Success?*, 39 J.L. MED. & ETHICS 387 (2011).

106. NAT'L PREVENTION COUNCIL, *supra* note 102, at 7.

107. *Id.*

source of care.[108] Others may have no health insurance or may move in and out of health plans and Medicaid.[109] Interruptions in care may exacerbate illnesses, leading to more intensive and expensive acute care. The ACA takes steps to make more consistent access to care possible by requiring health insurance to be available regardless of health status and by providing subsidies or enrollment in Medicaid for those unable to afford private insurance.[110] It also provides financial incentives for providers to create accountable care organizations to coordinate care.[111] However, it retains the existing patchwork of public and private health plans, leaving patients, including those with chronic illnesses, vulnerable to shifting in and out of different plans with different providers. Thus, the most specific efforts to reduce the cost of chronic illness fall on the individuals themselves, especially through wellness programs, which do not require major economic or institutional upheavals.[112]

IV. CHRONIC DISEASE: PREVENTION, COSTS, AND WELLNESS PROGRAMS

A. Chronic Disease: Prevalence and Causes

Given the general concern about the cost of chronic diseases and the ACA's encouragement of changing personal behaviors that increase the risk of such diseases, it seems important to know whether policies like wellness programs can either improve health or control costs. First, there is good reason to focus policy recommendations on reducing the disability and discomfort caused by

108. About 45% of people with public insurance have at least two chronic conditions, compared with one-third of people with private insurance and 16% of uninsured persons. STEVEN MACHLIN ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICAL EXPENDITURE PANEL SURVEY: STATISTICAL BRIEF # 320: HEALTH CARE ACCESS AND EXPENDITURES AMONG NON-ELDERLY ADULTS WITH MULTIPLE CHRONIC CONDITIONS: VARIATIONS BY INSURANCE COVERAGE STATUS, 2007-2008 (AVERAGE ANNUAL) 1-2 (2011), *available at* http://meps.ahrq.gov/mepsweb/data_files/publications/st320/stat320.pdf. More than 25% of these uninsured had no usual source of care, compared with 12.1% of those with public insurance and 8.7% of those with private insurance. *Id.*

109. Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, 30 HEALTH AFFS. 228, 232-36 (2011).

110. Patient Protection and Affordable Care Act §§ 1411-1415 (subsidies and tax credits); §§ 2001-2001 (expanded eligibility for Medicaid).

111. *See supra* note 6.

112. Starr, *supra* note 3, at 261 (concluding that the ACA's wellness provision "seeks to raise the cost of unhealthy practices").

chronic diseases.[113] More than half of all deaths in the United States (54%) in 2007 were attributable to heart disease, cancers, and stroke (53% in 2009).[114] Final data on the top ten causes of death in 2007 are shown in Table 1.[115]

TABLE 1: LEADING CAUSES OF DEATH, FINAL DATA FOR 2007

Cause of Death	Number	% of Total Deaths
All causes	2,423,712	100.0
Diseases of heart	616,067	25.4
Malignant neoplasms [cancers]	562,875	23.2
Cerebrovascular diseases [stroke]	135,952	5.6
Chronic lower respiratory diseases	127,952	5.3
Accidents [unintentional injuries]	123,706	5.1
Alzheimer's disease	74,632	3.1
Diabetes mellitus	71,382	2.9
Influenza and pneumonia	52,717	2.2
Nephritis, nephritic syndrome and nephrosis	46,448	1.9
Septicemia	34,828	1.4

Second, there is considerable evidence that certain behavioral factors increase the risk of chronic disease.[116] Like most observers,

113. P'SHIP FOR SOLUTIONS, CHRONIC CONDITIONS: MAKING THE CASE FOR ONGOING CARE 24 (Gerard Anderson et al. eds., John Hopkins Univ., 2004) (2002), *available at* http://www.partnershipforsolutions.org/DMS/files/chronicbook2004.pdf.

114. Melonie Heron, *Deaths: Leading Causes for 2007*, 59 NAT'L VITAL STAT. REP. 1, 9 tbl.C (2011), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_08.pdf. For a history and explanation of the classification of causes of death, see IWAO M. MORIYAMA ET AL., HISTORY OF THE STATISTICAL CLASSIFICATION OF DISEASES AND CAUSES OF DEATH (Harry M. Rosenberg & Donna L. Hoyert eds. 2011), *available at* http://www.cdc.gov/nchs/data/misc/classification_diseases2011.pdf.

115. Heron, *supra* note 114. Preliminary data for 2009 show similar results, except that suicide overtook septicemia as the tenth leading cause. Kenneth D. Kochanek et al., *supra* note 8, at 5 tbl.B.

116. *See supra* notes 9-10; CTRS FOR DISEASE CONTROL AND PREVENTION & THE MERCK CO. FOUND., THE STATE OF AGING AND HEALTH IN AMERICA (2007), *available at* http://www.cdc.gov/Aging/pdf/saha_2007.pdf.

WHO lists physical inactivity, poor diet, smoking, and harmful alcohol use as the key behavioral risk factors for chronic diseases.[117] Somewhat paradoxically, the prevalence of several key risk factors for heart disease—high cholesterol, high blood pressure, and tobacco use—has declined among people in all weight categories since 1960, the same period in which chronic disease prevalence rose.[118] A substantial body of research demonstrates that the social determinants of health, including income, education, employment, housing, genetics, the environment, and even political inequality, contribute significantly to the development of chronic diseases.[119] Given the multiplicity of factors contributing to non-infectious diseases, it is difficult to tease out exactly how much is attributable to behavior, as distinct from social determinants like genetics or unemployment, for example. The structural factors, of course, are more resistant to change. Thus, it is not surprising that those seeking more immediate results focus on individual behavior.

Reports about the separate links between chronic disease, on one hand, and behavioral risks, treatment costs, or premature

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117. WORLD HEALTH ORG., *supra* note 9, at vii.

118. Edward W. Gregg et al., *Secular Trends in Cardiovascular Disease Risk Factors According to Body Mass in U.S. Adults*, 293 JAMA 1868, 1874 (2005) (also finding that diabetes increased).

119. *See, e.g.*, David A. Alter et al., *Lessons from Canada's Universal Health Care: Socially Disadvantaged Patients Use More Health Services, Still Have Poorer Health*, 30 HEALTH AFFs. 274 (2011); Jason Beckfield & Nancy Krieger, *Epi+Demos+Cracy: Linking Political Systems and Priorities to the Magnitude of Health Inequalities—Evidence, Gaps, and a Research Agenda*, 31 EPIDEMIOLOGY REV. 152 (2009) (countries with social safety nets tend to have fewer inequalities and fewer health disparities); Sandro Galea et al., *Estimated Deaths Attributable to Social Factors in the United States*, 101 AM. J. PUB. HEALTH 1456 (2011); M. David Low et al., *Can Education Policy Be Health Policy? Implications of Research on the Social Determinants of Health*, 30 J. HEALTH POL. POL'Y & L. 1131 (2005); Jo C. Phelan et al., *Social Conditions as Fundamental Causes of Health Inequalities: Theory, Evidence and Policy Implications*, 51 J. HEALTH & SOC. BEHAV. S28 (2010); David J. Roelfs et al., *Losing Life and Livelihood: A Systematic Review and Meta-Analysis of Unemployment and All-Cause Mortality*, 72 SOC. SCI. & MED. 840 (2011); A. Siddiqi, D. Zuberi & Q. C. Nguyen, *The Role of Health Insurance in Explaining Immigrant Versus Non-immigrant Disparities in Access to Health Care: Comparing the United States to Canada*, 69 SOC. SCI. MED. 1452 (2009); Marilyn A. Winkeby et al., *Social Class Disparities in Risk Factors for Disease: Eight-Year Prevalence Patterns by Level of Education*, 19 PREVENTIVE MED. 1 (1990); INSTIT. OF MED., Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (Brian D. Smedley et al., eds., 2003); N. WALLERSTEIN, WHAT IS THE EVIDENCE ON EFFECTIVENESS OF EMPOWERMENT TO IMPROVE HEALTH? (2006), *available at* http://www.euro.who.int/__data/assets/pdf_file/0010/74656/E88086.pdf; WORLD HEALTH ORG., SOCIAL DETERMINANTS OF HEALTH: THE SOLID FACTS (Richard Wilkinson & Michael Marmot eds., 2d ed. 2003), *available at* http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf.

death, on the other hand, can invite some rhetorical leaps.[120] For example, in a 2007 report, the Centers for Disease Control and Prevention began its description of behavioral factors that cause disease with the heading "More than one-third of U.S. deaths are preventable."[121] This is nonsense, of course. In the long run, no one's death is preventable. Similarly, a video on the website homepage of HealthMedia, Inc., which sells digital coaching programs, claims "seventy percent of healthcare costs can be prevented through behavior change."[122] Would that it were true. About 75% of deaths from chronic diseases worldwide occur among those over sixty years of age.[123] At least in the developed world, people are escaping infectious diseases and accidents and living long enough to succumb to heart diseases, stroke, and cancers. The most likely general consensus is that we all hope to prevent disabling conditions that make life difficult, especially among the young. Therefore, to the extent that disabling conditions can be prevented—and, ideally, the years of healthy life increased—preventive measures are to be greatly desired.

Whether prevention can reduce the costs of chronic diseases is a different question. Certainly, worry about such costs is widespread. And, it is logical to believe that a reduction in chronic disease would also reduce treatment costs. The National Prevention Strategy states that prevention can lower health care costs.[124] A report for the World Economic Forum estimated that in 2010, worldwide direct and indirect costs were $863 billion for cardiovascular diseases, $500 billion for diabetes, $458 billion for cancers, $2.1 trillion for chronic obstructive pulmonary disease, and $2.5 trillion for mental illnesses.[125] A recent study estimates that the total costs of obesity in the U.S. could be as high as $147 bil-

120. For example, an estimate of the number of deaths caused by behavioral factors was critiqued and later corrected in part by the authors. Ali H. Mokdad et al., *Actual Causes of Death in the United States 2000*, 291 JAMA 1238, 1243-45 (2004) (concluding that modifiable behavioral risk factors are the leading causes of mortality in the United States); Ali H. Mokdad et al., *Correction: Actual Causes of Death in the United States 2000*, 293 JAMA 293, 293 (2005).

121. CTRS FOR DISEASE CONTROL AND PREVENTION & THE MERCK CO. FOUND., *supra* note 116, at iii.

122. HEALTHMEDIA SOLUTIONS, http://healthmedia.com/index.htm#/300 (last visited Nov. 16, 2011). Such claims appear to confuse research attributing between 50% to 70% of health care costs in certain populations to chronic disease and separate findings that certain behaviors are associated with the development of chronic diseases.

123. WORLD HEALTH ORG., *supra* note 9, at ix.

124. NAT'L PREVENTION COUNCIL, *supra* note 102, at 6.

125. BLOOM ET AL., *supra* note 8.

lion.[126] The federal government is obviously concerned, because Medicare pays an estimated 23% of these costs, while Medicaid pays an estimated 19%.[127] However, the study that estimated these costs also estimated that, without obesity, costs would only be 7% to 11% lower.[128]

Studies of chronic disease costs require some parsing. Most studies are based on separate estimates of the prevalence of a chronic disease like heart disease, risk factors like obesity for heart disease, and the costs of services for diseases for which obesity is a risk factor. Actual data on the costs of care for illnesses that are caused by obesity alone are hard to find. Many researchers use the Medical Expenditure Panel Survey ("MEPS"), a periodic survey of a representative national sample of the civilian noninstitutionalized population that asks about medical spending, health insurance status, health status, and body mass index ("BMI"), or the National Expenditures Accounts, which also includes institutionalized adults.[129] Different studies use different time periods (e.g., annual or lifetime), different populations (e.g., elderly, non-elderly, or children), and different types of costs (e.g., medical care, all health expenditures, or government expenditures, including disability and pension payments).[130] There is general agreement that the cost of medical care to treat chronic conditions is increasing, but there are several possible reasons for the increase, not all of them easily amenable to prevention. For example, much of the cost has been attributed to the growing proportion of elderly in the population,[131] the increased costs of medi-

126. Eric A. Finkelstein et al., *Annual Medical Spending Attributable to Obesity: Payer—and Service—Specific Estimates*, 28 HEALTH AFFS. w822, w828-w831 (2009). *See also* Angela B. Mariotto et al., *Projections of the Cost of Cancer Care in the United States: 2010–2020*, 103 J. NAT'L. CANCER INST. 117, 126 (2011); CONG. BUDGET OFFICE, *supra* note 7.

127. Justine G. Trogdon et al., *State—and Payer—Specific Estimates of Annual Medical Expenditures Attributable to Obesity*, 20 OBESITY 214 (2011), *available at* http://www.nature.com/oby/journal/vaop/ncurrent/pdf/oby2011169a.pdf.

128. *Id.* at 4.

129. The Medical Expenditure Panel Survey, begun in 1996, is described at *Survey Background*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, http://www.meps.ahrq.gov/mepsweb/about_meps/survey_back.jsp (last updated August 21, 2009).

130. *See, e.g.*, Katherine M. Flegal et al., *Prevalence and Trends in Obesity Among U.S. Adults, 1999-2008*, 303 JAMA 235 (2010).

131. CTRS. FOR DISEASE CONTROL AND PREVENTION & THE MERCK CO. FOUND., *supra* note 116, at 5. *But see* Uwe Reinhardt, *Does the Aging of the Population Really Drive the Demand for Medical Care*?, 22 HEALTH AFFS. 27, 34-35 (2003) (noting that in the United States, the age distribution does not explain all of the increase in health care costs). A larger population necessarily incurs more costs, but should also produce a larger GDP. ROBERT J. BARRO, HEALTH AND ECONOMIC GROWTH (1996), *available at* www.paho.org/

cal technology and services,[132] and the increased incidence of chronic disease.[133]

It is possible that the costs of chronic diseases have increased in part because more people have been diagnosed with a disease than in the past, when some individuals might not have recognized a problem—hypertension or metabolic syndrome, for example—as warranting medical attention. H. Gilbert Welch and colleagues argue that the medical paradigm has shifted from one in which patients see physicians when they have symptoms to one in which everyone is encouraged to be screened for many possible conditions when they have no symptoms of disease.[134] Increasingly, sophisticated diagnostic technologies enable physicians to find smaller and smaller abnormalities, which may or may not develop into symptomatic diseases.[135] This increased screening can increase the number of conditions found without necessarily changing the resulting health outcomes in the long-term.[136] Increased screening for disease has the advantage of identifying some problems at an early enough stage to permit curative treatment,[137] but screening itself has costs, including the costs of the screening tests, unnecessary treatment for false positives, and sometimes adverse reactions and complications from unnecessary treatment.[138] The controversies over mammograms and PSA testing are recent examples of the complexity of determining the value of screening for diseases.[139] Correctly diagnosing diseases brings

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ENGLISH/HDP/HDD/barro.pdf (finding that a 5-year increase in life expectancy could result in a 0.3-0.5% increase in GDP growth rate).

132. SHEILA D. SMITH ET AL., THE IMPACT OF TECHNOLOGICAL CHANGE ON HEALTH CARE COST SPENDING: AN EVALUATION OF THE LITERATURE (2000), *available at* http://www.cms.gov/NationalHealthExpendData/downloads/tech_2000_0810.pdf. *See* Melinda J. Beeuwkes Buntin et al., *Increased Medicare Expenditures for Physicians' Services: What Are the Causes?*, 41 INQUIRY 83 (2004) (noting that new technologies have contributed to rising costs).

133. *See, e.g.*, Flegal et al., *supra* note 130; Hoffman et al., *supra* note 7.

134. H. GILBERT WELCH ET AL., OVERDIAGNOSED: MAKING PEOPLE SICK IN THE PURSUIT OF HEALTH xii (2011).

135. *Id.* at 35

136. *Id.* at 44.

137. For example, treatment of hypertension can prevent or delay heart disease. K.L. Ong et al., *Prevalence, Awareness, Treatment, and Control of Hypertension among United States Adults 1999-2004*, 49 HYPERTENSION 69, 73-74 (2007).

138. WELCH ET AL., *supra* note 134, at 168-171.

139. *Id.* at x-xi; Gina Kolata, *Mammogram Debate Took Group by Surprise*, N.Y. TIMES, Nov. 20, 2009, http://www.nytimes.com/2009/11/20/health/20prevent.html?_r=1&emc=eta1; Allan S. Brett & Richard J. Ablin, *Prostate-Cancer Screening—What the U.S. Preventive Services Task Force Left Out*, 365 NEW ENG. J. MED. 1949 (2011), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1112191.

more patients into treatment, and treatment modalities are often more intensive and expensive than those used several decades ago.[140] Thus, improved screening and treatment brings a mix of personal benefits and additional costs.

Successful preventive or treatment measures are valuable, because they enable people to live longer, healthier lives.[141] That should be sufficient reason to encourage their use. Yet, the justification for prevention routinely includes the assumption that prevention saves money.[142] Some preventive measures, especially immunizations and adults taking low-dose aspirin, appear to save money.[143] Estimates of the costs of chronic diseases that are attributed to specific risk factors, such as smoking and obesity, can be misunderstood to mean that the amount of those costs could be saved if those risk factors were eliminated.[144] That assumes that people without those risk factors would not incur costs for other diseases, whereas almost everyone will incur some health care costs, if only at the end of life. If we are lucky, those costs will be less for healthy people than for those with chronic illnesses.

We might not be lucky. Most studies finding that health care costs are higher for those with chronic diseases do not account for lifetime costs of care.[145] The longer people live, the longer they will

140. Charles S. Roehrig & David M. Rousseau, *The Growth in Cost Per Case Explains Far More of US Health Spending Increases Than Rising Disease Prevalence*, 30 HEALTH AFFS. 167, 169 (2011) ("increases in treated prevalence account for about one-fourth of overall growth in real per capita spending, with the remainder attributable to growth in cost per case"); Kenneth E. Thorpe & David H. Howard, *The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity*, 25 HEALTH AFFS. w378 (2006) (estimating that about half of the increase in per capita spending for Medicare beneficiaries was attributable to increases in per capita spending, with about half due to population aging).

141. For example, most pediatric immunizations prevent deaths from infectious diseases. Ctrs for Disease Control and Prevention, U.S. Dep't of Health & Human Servs., Ten Great Public Health Achievements—United States, 2001-2010, 60 MORBIDITY & MORTALITY WKLY. REP. 619, 619 (2011), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6019a5.htm.

142. *See, e.g.*, Jeffrey Levi et al., *Healthier Americans for a Healthier Economy*, HEALTHY AMERICANS ISSUE BRIEF (TRUST FOR AM.'S HEALTH, Washington, D.C.), Oct. 2011, at 1, *available at* http://healthyamericans.org/assets/files/TFAH2011PreventEconomy05.pdf; P'SHIP FOR SOLUTIONS, *supra* note 113.

143. Sarah Goodell et al., *Cost Savings and Cost-effectiveness of Clinical Preventive Care*, THE SYNTHESIS PROJECT (ROBERT WOOD JOHNSON FOUND., Princeton, N.J.), Sept. 2009, at 1, *available at* http://www.rwjf.org/files/research/092209.policysynthesis.preventivecare.brief.pdf.

144. *See* HEALTHMEDIA SOLUTIONS, *supra* note 122.

145. *See, e.g.*, Nicolaas P. Pronk et al., *Relationship Between Modifiable Health Risks and Short-term Health Care Charges*, 282 JAMA 2235, 2235 (1999) (finding that those who were physically active, did not smoke, and were not overweight had almost half (49%) the health care costs attributable to non-healthy adults over age forty).

continue to get medical care. Thus, the total lifetime costs of care for healthy, elderly people are similar to the costs for more seriously ill people who die at a younger age.[146] There is even evidence that healthy people incur more lifetime health care costs than people who are obese or who use tobacco, because healthy people live longer.[147] Indeed, the general consensus of economists and actuaries is that few preventive measures can reduce lifetime costs of health care.[148] In 2009, before the ACA was enacted, the director of the Congressional Budget Office, Douglas W. Elmendorf, concluded that "[a]lthough different types of preventive care have different effects on spending, the evidence suggests that for most preventive services, expanded utilization leads to higher, not lower, medical spending overall."[149]

Assumptions about the costs of chronic diseases also depend upon who is paying. The federal government's budget must include the costs of Social Security, Medicare, and the Department of Veterans Affairs, as well as increased Medicaid expenditures for a newly expanded eligible population, so it must plan for the future population of elderly and disabled.[150] Medicaid and the State Children's Health Insurance Program covered forty-five million

146. *See, e.g.*, James Lubitz et al., *Health, Life Expectancy, and Health Care Spending Among the Elderly*, 349 NEW ENG. J. MED. 1048 (2003) (finding that Medicare beneficiaries' health status has little or no effect on total Medicare costs).

147. Pieter H.M. van Baal et al., *Lifetime Medical Costs of Obesity: Prevention No Cure for Increasing Health Expenditure*, 5 PLOS MED. 0242, 0242 (2008); Kenneth E. Warner, *The Economics of Tobacco: Myths and Realities*, 9 TOBACCO CONTROL 78, 81 (2000). *See also* June Stevens et al., *The Effect of Age on the Association Between Body-Mass Index and Mortality*, 338 NEW ENG. J. MED. 1 (1998) (finding that treatment costs were lower for smokers than for the obese).

148. COST-EFFECTIVENESS IN HEALTH AND MEDICINE 10 (Marthe R. Gold et al. eds., 1996); Joshua T. Cohen et al., *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 NEW ENG. J. MED. 661 (2008); Matthew G. Marin & Jessica Nutik Zitter, *Expenditures Associated with Preventive Healthcare*, 39 PREVENTIVE MED. 856 (2004); Louise B. Russell, *Preventing Chronic Disease: An Important Investment, but Don't Count on Cost Savings*, 28 HEALTH AFFS. 42, 42 (2009). *See also* Patrick McGeehan, *U.S. Rejects Mayor's Plan to Ban Use of Food Stamps to Buy Soda*, N.Y. TIMES, Aug. 19, 2011, http://www.nytimes.com/2011/08/20/nyregion/ban-on-using-food-stamps-to-buy-soda-rejected-by-usda.html (noting that the United States Department of Agriculture concluded that prohibiting the use of food stamps to buy soda, as requested by New York City Mayor Bloomberg, would not necessarily reduce obesity or improve health).

149. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Nathan Deal, Ranking Member of the Subcomm. on Health of the Comm. on Energy and Commerce of the U.S. House of Representatives (Aug. 7, 2009) (on file with the Cong. Budget Office), *available at* http://www.cbo.gov/ftpdocs/104xx/doc10492/08-07-Prevention.pdf.

150. *See* Nicole Huberfield, Federalizing Medicaid, 14 U. PA. J. CONST. L. (forthcoming 2011) (describing the ACA's expansion of Medicaid); Gina Livermore et al., *Health Care Costs Are a Key Driver of Growth in Federal and State Assistance to Working-Age People with Disabilities*, 30 HEALTH AFFS. 1664, 1664 (2011).

people (16.9% of the nonelderly population) in 2010.[151] However, employers are primarily concerned with their workforce before retirement.[152] Preventive measures may indeed delay some serious illnesses and expensive medical care until the population is elderly.

The Centers for Medicare and Medicaid are well aware of the need to control the costs of caring for their growing populations. In 2005, Medicare began pilot testing its Health Support Program, in which eight care management companies received $2,000 per patient to improve health behaviors and outcomes in Medicare beneficiaries with heart disease or diabetes.[153] The companies were expected to save their fees, plus 5% of patient costs.[154] However, the program was stopped after three years, when Medicare costs per patient increased by 5% to 11%, and most companies were unable to save even their own fees.[155] Recent research suggests that highly intensive and tightly coordinated care for patients who are elderly or have chronic diseases can improve both the quality of care and patient outcomes.[156] Whether they can save money remains to be seen.

B. Employee Wellness Programs

Most polls show that employers remain worried about rising health insurance costs and continue to try to contain costs by rais-

151. Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2011 Current Population Survey*, EBRI ISSUE BRIEF (Emp. Benefit Research Inst., Washington, D.C.), Sept. 2011, at 1, *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-2011_No362_Uninsured1.pdf (reporting that public health benefit programs, including Medicare, which covers certain disabled nonelderly, covered 21.6% of the total nonelderly population).

152. EMP. BENEFIT RESEARCH INST. & MATHEW GREENWALD & ASSOCS., INC., 2011 RCS FACT SHEET #5: CHANGING EXPECTATIONS ABOUT RETIREMENT 4 (2011), *available at* http://www.ebri.org/pdf/surveys/rcs/2011/FS5_RCS11_Expects_FINAL1.pdf (noting that a declining proportion of employers offer health benefits).

153. Ctrs. for Medicare and Medicaid Servs., *Overview*, U.S. DEP'T OF HEALTH & HUMAN SERVS., https://www.cms.gov/ccip/ (last updated Nov. 29, 2011) (noting that 14% of Medicare beneficiaries have heart disease, but account for 43% of spending, and that 18% have diabetes and account for 32% of spending).

154. NANCY MCCALL ET AL., EVALUATION OF PHASE I OF THE MEDICARE HEALTH SUPPORT PILOT PROGRAM UNDER TRADITIONAL FEE-FOR-SERVICE MEDICARE: 18-MONTH INTERIM ANALYSIS, REPORT TO CONGRESS, 6, 14 (2008), https://www.cms.gov/reports/downloads/MHS_Second_Report_to_Congress_October_2008.pdf. The 5% savings requirement was removed in 2007. *Id*. at 69.

155. *Id.* at 77-78.

156. *See* Chad Boult et al., *The Effect of Guided Care Teams on the Use of Health Services: Results from a Cluster-Randomized Controlled Trial*, 171 ARCH INTERN MED. 460 (2011).

ing deductibles, increasing paycheck contributions, and moving employees to lower-cost health plans.[157] Disease management or wellness programs are an increasingly popular addition to employer cost control methods.[158] Indeed, there is an entire industry devoted to designing and administering such programs, either as part of a health insurance plan or as a separate program.[159] Safeway became the poster child for using wellness programs to save health insurance costs.[160] The ACA amendment to the HIPAA provision governing wellness programs, discussed above, was commonly called the Safeway Amendment.[161] However, Safeway's cost controls were not necessarily attributable to its Healthy Measures wellness program, which enrolled less than 9% of its employees.[162] Safeway's savings occurred following a 2006 plan change that increased the employee's share of premium costs from 20% to 55%.[163]

A majority of large employers appear to welcome wellness programs.[164] Small employers are less likely to offer wellness pro-

157. Elizabeth Pendo, *Working Sick: Lessons of Chronic Illness for Health Care Reform*, 9 YALE J. HEALTH POL'Y L. & ETHICS 453, 457-59. (2009). *See also* Deborah Brunswick, *Health Insurance Costs to Rise Again Next Year*, CNN MONEY, Sept. 22, 2011, http://money.cnn.com/2011/09/22/pf/health_insurance_costs/ (noting that premiums are expected to rise 5.4%, which is less than recent increases, but still more than the 3.9% general inflation rate/consumer price index); ROBIN A. COHEN & MICHAEL E. MARTINEZ, NAT'L CTR. FOR HEALTH STATISTICS, CTRS. FOR DISEASE CONTROL AND PREVENTION, HEALTH INSURANCE COVERAGE: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, JANUARY-MARCH 2011 (2011), http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201109.pdf. Employers' growing use of high-deductible, consumer-directed health plans may or may not affect employees' use of preventive care. John W. Rowe et al*., The Effect of Consumer-Directed Health Plans on the Use of Preventive and Chronic Illness Services*, 27 HEALTH AFFS. 113 (2008).

158. Seff v. Broward Cnty, 778 F. Supp. 2d 1370, 1375 (S.D. Fla. 2011) ("It is the economic loss suffered by employers that spurs the development of these programs, not some beneficent wish for its employees to be healthy.").

159. *See generally* CARE CONTINUUM ALLIANCE, http://www.carecontinuum.org/index.asp (formerly named the Disease Management Association of America).

160. Steven A. Burd, *How Safeway is Cutting Health-Care Costs,* WALL ST. J., June 12, 2009, at A15. *See* JOHN E. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM 192 (2011) (reporting that Safeway's president, Steven Burd, "convinced Democrat and Republican members alike that he had found a personal-responsibility path to controlling health care costs").

161. David S. Hilzenrath, *Misleading Claims about Safeway Wellness Incentives Shape Health-Care Bill*, WASH. POST, Jan. 17, 2010, at G01.

162. *Id. See* MCDONOUGH, *supra* note 160, at 193 (Congressional Budget Office staff concluded that "Safeway is largely a myth").

163. *Id.*

164. Michelle M. Mello & Meredith B. Rosenthal, *Wellness Programs and Lifestyle Discrimination—The Legal Limits*, 359 NEW ENG. J. MED. 192, 192 (2008); NAT'L BUS. GRP. ON HEALTH & TOWERS WATSON, THE ROAD AHEAD: SHAPING HEALTH CARE STRATEGY IN A POST-REFORM ENVIRONMENT 15 (2011), http://www.towerswatson.com/assets/pdf/3946/

grams, perhaps because they cannot afford the initial investment required to purchase a gym or the services of an independent disease management company.[165] Employers promote such programs as evidence of their concern for the health of their employees; however, many employers focus primarily on the hope that wellness programs can reduce the costs of health insurance, decrease absenteeism, and improve employee productivity.[166] Indeed, most disease management companies market their programs to employers by promising positive returns on the investment. Whether employers can reap the financial rewards of a successful wellness program depends upon how long it takes for a change in behavior to improve health, reduce costs, and decrease employee turnover. Changes that produce relatively immediate effects, such as feeling better after smoking cessation, can improve productivity within a relatively short time. However, programs that target risks for chronic diseases, such as blood sugar levels and obesity, may not have significant effects for many years. In this era of frequent job changes, an employer may invest a great deal in employees who save money for a future employer. Moreover, since the majority of healthcare costs are attributable to chronic diseases among the elderly and in the last year of life, it will be Medicare, not the employer, who is most likely to save healthcare costs. However, a healthy employee who lives a very long life and receives Social Security benefits may cost the federal government more in pensions than it saves in Medicare costs.[167]

Employers appear to be more enthusiastic about health promotion than employees. Some employees may welcome wellness programs and workplace incentives as a source of motivation, especially one that does not involve nagging family members.[168] Others may support wellness programs for fear that rising health care

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TowersWatson-NBGH-2011-NA-2010-18560.pdf; KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS: 2011 ANNUAL SURVEY 168 (2011), *available at* http://ehbs.kff.org/pdf/2011/8225.pdf. Small employers also are less likely than large employers to offer health plans. *Id.* at 34.

165. Tu & Mayrell, *supra* note 67, at 2.

166. *Id. See* KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUCATIONAL TRUST, *supra* note 164 (reporting that the majority of employers surveyed who offer wellness programs said their goal is "to improve the health of employees and reduce absenteeism"). At the same time, 26% of all employers surveyed identified disease management as a "very effective" strategy to control costs. *Id.* at 194.

167. Timothy Westmoreland, *Can We Get There from Here? Universal Health Insurance and the Congressional Budget Process*, 96 GEO. L.J. 523, 529 (2008).

168. *See* RICHARD H. THALER & CASS R. SUNSTEIN, NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS (2008).

costs attributable to unhealthy employees may reduce overall compensation. Some employees, however, may find the programs intrusive or fear losing their job if they fail to meet expectations.

A Wellpoint report states that almost 75% of employers offered their employees a wellness program in 2008.[169] But not all employees, typically less than half, accepted the offer.[170] One study of a reasonably successful employer program found that, of those employees identified as at risk or eligible for a wellness program, 78% were successfully contacted by telephone.[171] Of those contacted, 48% agreed to participate in the program, but less than half (45%) of those who began the program stayed for at least six months—17% of the original target population.[172] IncentOne, a company that sells health promotion and disease management programs to health insurers and employers, claims that participation rates may be only 10-15% when incentives are not offered.[173] Its website advocates using incentives to get employees into programs, stating that "84% of CEOs see incentives as [the] most important tool."[174]

Incentives may indeed make a difference, both in participation rates and outcomes, at least in the short run.[175] Economists and psychologists have long argued that people respond to financial incentives.[176] New York City is among several jurisdictions that

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169. *Helping People Help Themselves: Driving Participation in Health Improvement Programs*, INST. OF HEALTH CARE KNOWLEDGE—RESEARCH SUMMARY (WELLPOINT INST. OF HEALTH CARE KNOWLEDGE), Aug. 2009, at 1, *available at* http://www.wellpoint.com/prodcontrib/groups/wellpoint/@wp_news_research/documents/wlp_assets/pw_d014924.pdf.

170. *Id.* at 2.

171. Wendy D. Lynch et al., *Documenting Participation in an Employer-Sponsored Disease Management Program: Selection, Exclusion, Attrition, and Active Engagement as Possible Metrics*, 48 J. OCCUPATIONAL ENVTL. MED. 447, 450 (2006). The number of employees deemed to be at risk was not specified. *Id*.

172. *Id.* at 452.

173. *The Science of Health Incentives*, INCENTONE (Nov. 2009), http://www.incentone.com/index.php?option=com_smartformer&Itemid=173.

174. *The Value of Health Incentives*, INCENTONE, http://www.incentone.com/index.php?option=com_content&view=article&id=72&Itemid=74 (last visited Feb. 17, 2012).

175. *See* Kate Cahill & Rafael Perera, *Competitions and Incentives for Smoking Cessation*, COCHRANE DATABASE OF SYSTEMATIC REVIEWS (Cochrane Collaboration, London, England), Apr. 13, 2011, at 1, 2; Leslie K. John et al., *Financial Incentives for Extended Weight Loss: A Randomized Controlled Trial*, 26 J. GEN. INTERNAL MED. 621, 625 (2011); Kim Sutherland et al., *Impact of Targeted Financial Incentives on Personal Health Behavior: A Review of the Literature,* 65 MED. CARE RESEARCH & REV. 36S, 38S-39S (2008).

176. *See, e.g.*, George Loewenstein et al., *Asymmetric Paternalism to Improve Health Behaviors*, 298 JAMA 1425 (2007) (encouraging use of incentives to encourage people to engage in beneficial behaviors, while acknowledging that this will be controversial); John Cawley & Christopher J. Ruhm, *The Economics of Risky Health Behaviors* 100-103 (Nat'l Bureau of Econ. Research, Working Paper No. 17081, 2011).

have paid people to get medical examinations or tests.[177] A reward of $750 increased smoking cessation for a year in one randomized, controlled trial.[178] Florida introduced a program to reward Medicaid recipients for engaging in certain healthy behaviors with vouchers to purchase medical products not covered by Medicaid at retail pharmacies, but participation in the program is still low.[179] In contrast, Arizona Governor Jan Brewer's proposal to charge a fifty dollar fee to Medicaid beneficiaries, including those who smoke or are obese, provoked controversy, perhaps because it did not offer beneficiaries any new assistance or other benefit in return for the fee.[180]

Simply providing insurance coverage for additional benefits can operate as an incentive to get preventive care, by removing the need to pay out of pocket. This is undoubtedly the motivation behind state and ACA requirements for insurers to cover preventive services. It is also consistent with research findings that an important reason that people fail to seek medical care is the cost of that care.[181] Medicare Part D appears to have increased recommended prescription drug use among Medicare beneficiaries.[182] Cost-sharing, such as high co-payments or deductibles, can dis-

177. JAMES RICCIO ET AL., TOWARD REDUCED POVERTY ACROSS GENERATIONS: EARLY FINDINGS FROM NEW YORK CITY'S CONDITIONAL CASH TRANSFER PROGRAM iii (2010), *available at* http://www.mdrc.org/publications/549/full.pdf. Mexico has tried similar programs. *Id.* at xv.

178. Kevin G. Volpp et al., *A Randomized, Controlled Trial of Financial Incentives for Smoking Cessation*, 360 NEW ENG. J. MED. 699, 708 (2009).

179. GREENE, *supra* note 90, at 8-9.

180. Janet Adamy, *Arizona Proposes Medicaid Fat Fee*, WALL ST. J., Apr. 1, 2011, http://online.wsj.com/article/SB10001424052748704530204576235151262336300.html (noting that 25.5% of Arizona residents were obese and that its Medicaid program needed additional revenue).

181. *See* Lisa Dubay et al., *The Uninsured and the Affordability of Health Insurance Coverage*, 26 HEALTH AFFS. w22, w23 (2007); MAMANTHA PANCHOLI, U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICAL EXPENDITURE PANEL SURVEY: STATISTICAL BRIEF #32: REASONS FOR LACKING A USUAL SOURCE OF CARE: 2001 ESTIMATES FOR THE U.S. CIVILIAN NONINSTITUTIONALIZED POPULATION (2004), *available at* http://www.meps.ahrq.gov/mepsweb/data_files/publications/st32/stat32.pdf; ROBIN M. WEINICK ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICAL EXPENDITURE PANEL SURVEY: RESEARCH FINDINGS #3: ACCESS TO HEALTH CARE—SOURCES AND BARRIERS, 1996 4 (1997), *available at* http://meps.ahrq.gov/mepsweb/data_files/publications/rf3/rf3.shtml. *See generally* SUSAN S. SERED & RUSHIKA FERNANDOPULLE**,** UNINSURED IN AMERICA: LIFE AND DEATH IN THE LAND OF OPPORTUNITY (2005).

182. *See* James J. Kennedy et al., *Cost-Related Nonadherence in the Medicare Program: The Impact of Part D*, 49 MED. CARE 522, 522 (2011). Prescription drug coverage was added to the Medical program as Part D of Title XVIII of the Social Security Act, effective in 2006. 42 U.S.C. §§ 1860D-1 to 1860D-31 (2006).

courage even those with health insurance from getting care.[183] A recent study of the addition of co-payments for cancer drugs for Georgia's Medicaid beneficiaries found that the Georgians reduced their acquisition of prescription drugs, compared with two states that did not impose co-payments.[184] Emergency room visits for Georgia Medicaid patients also increased.[185] After six months, the Georgia Medicaid population cost $2,000 more per patient than those in the other two states.[186]

Eliminating cost-sharing for preventive services, as the ACA does, also has increased the use of preventive care.[187] People with chronic diseases are more likely to delay or avoid care when their insurance requires point-of-service costs like deductibles and co-pays.[188] This strongly suggests that eliminating cost-sharing is likely to encourage people to obtain preventive services and improve health. However, increasing cost-sharing or denying discounts to people who do not successfully participate in wellness programs may discourage people from getting services that would benefit them.

Incentives that go beyond removing cost obstacles, like Arizona's Medicaid proposal, may face resistance. West Virginia's Medicaid program received a waiver to offer an Enhanced Benefit

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183. *See generally* Willard G. Manning et al., *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*, 77 AM. ECON. REV. 251 (1987).

184. Sujha Subramanian, *Impact of Medicaid Copayments on Patients with Cancer: Lessons for Medicaid Expansion Under Health Reform*, 49 MED. CARE 842, 843-45 (2011). After co-payments were imposed, Georgians reduced their supplies of prescription drugs by 127 days compared to Texas and by 150 days compared to South Carolina. *Id.* at 844.

185. *Id.* at 844.

186. *Id.*

187. *See* Michael E. Chernew et al., *Impact of Decreasing Copayments on Medication Adherence Within a Disease Management Environment*, 27 HEALTH AFFS. 103, 111 (2008) (reducing copayments for prescription drugs increased medication adherence by several percentage points); Niteesh K. Choudry et al., *Should Patients Receive Secondary Prevention Medications for Free After a Myocardial Infarction? An Economic Analysis*, 26 HEALTH AFFS. 186, 186 (2007) (finding cost savings and decreased mortality); Teresa B. Gibson, Ronald J. Ozminkowski & Ron Z. Goetzel, *The Effects of Prescription Drug Cost Sharing: A Review of the Evidence*, 11 AM. J. MANAGED CARE 730, 737 (2005); Dana P. Goldman et al., *Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health*, 298 JAMA 61, 61, 66 (2007).

188. *See* Goldman et al., *id.* at 65; John V. Jacobi, *Consumer-Directed Health Care and the Chronically Ill,* 38 U. MICH. J.L. REFORM 531, 566-67 (2005); Paul Fronstin & Sara R. Collins, *The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Survey, 2006: Early Experience with High-Deductible and Consumer-Driven Plans*, EBRI ISSUE BRIEF (Emp. Benefit Research Inst., Washington, D.C.), Dec. 2006, at 1, 33, *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2006/Dec/The%202nd%20Annual%20EBRI%20Commonwealth%20Fund%20Consumerism%20in%20Health%20Care%20Survey%20%202006%20%20Early%20Experience%20With/IB%20Dec06%20Final%20E%20CF%20Logos%20pdf.pdf.

Plan to beneficiaries who agree to certain responsibilities, including doing their best to stay healthy and attending health improvement programs as directed by their health providers.[189] Those who do not comply with the Enhanced Benefit Plan requirements and those who do not opt into the Enhanced Benefit Plan are kept in the Basic Benefits Plan, which has many fewer benefits.[190] In particular, Basic Benefits do not include diabetes care, weight management, nutrition education, smoking cessation, or substance abuse and mental health services—the very services that might mitigate the costs of chronic illness among the beneficiaries.[191] The program raised concerns among physicians, who were expected to monitor and perhaps enforce plan requirements.[192] One evaluation found that only 10 to 15% of Medicaid beneficiaries chose to participate in the Enhanced Benefit Plan in its first year, even though no enforcement procedures had been implemented.[193]

C. Evidence for Health Improvement

Wellness programs generally are expected to improve health and save money. The evidence for both is less than one would hope, but there is somewhat more good news for health improvement than for saving money.[194] There is a burgeoning literature on the effects of wellness programs, although most concede several limitations.[195] First, many studies were conducted in single workplaces with a relatively small sample size, making it difficult to determine whether the population is representative of all workers. In some cases, only a small proportion of employees participated.

189. *See* W. VA. DEP'T. OF HEALTH AND HUMAN RES., WEST VIRGINIA MEDICAID MEMBER AGREEMENT (DRAFT) (2005), *available at* http://www.wvdhhr.org/medred/handouts/wvmedicaidmemberagrmnt.pdf.

190. *See* W. VA. DEP'T. OF HEALTH AND HUMAN RES., CHAPTER 527: COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MOUNTAIN HEALTH CHOICES (2009), *available at* http://www.dhhr.wv.gov/bms/Documents/bms_manuals_Chapter_527MountainHealthChoices.pdf.

191. *Id.* at 23.

192. *See* Gene Bishop & Amy C. Brodkey, *Personal Responsibility and Physician Responsibility—West Virginia's Medicaid Plan*, 355 NEW ENG. J. MED. 756, 756-758 (2006).

193. MICHAEL HENDRYX ET AL., W. VA. UNIV. INST. FOR HEALTH POLICY RESEARCH, EVALUATION OF MOUNTAIN HEALTH CHOICES: IMPLEMENTATION, CHALLENGES, AND RECOMMENDATIONS (2009), *available at* http://www.hsc.wvu.edu/wvhealthpolicy/reports/WV_paper_rev%20FINAL.pdf.

194. *See* Mark A. Rothstein & Heather L. Harrell, *Health Risk Reduction Programs in Employer-Sponsored Health Plans: Part I—Efficacy*, 51 J. AM. C. OCCUPATIONAL & ENVTL. MED. 943 (2009) (summarizing studies).

195. *Id.* at 945, 949; Tu & Mayrell, *supra* note 67, at 6-7.

Second, some programs, especially the most successful, were highly individualized and intensive, with repeated interactions with employees, which may be difficult or expensive to translate elsewhere.[196] Third, some studies have no control groups against which to test the results in order to determine whether the program or external factors, such as growing public awareness of health risks, caused any change. Fourth, few studies are randomized, controlled trials, and so are unable to reject the possibility—some would say probability—that those who participate in wellness programs are more inclined to improve their health, even without any formal program, than those who do not participate.[197] Fifth, most reports review recently adopted, rather than mature, programs, whose results may change over time, assuming they remain in effect. Finally, few studies followed participants longer than six months, so it is not known whether the participants continued their changed behavior after the program ended. Indeed, literature reviews have concluded that behavior change is not necessarily sustained over time.[198] Not often mentioned is the possibility that studies of successful programs, like studies showing investigational drugs to be effective, are more likely to be published than studies showing little or no effect.[199] Companies that fund their own studies may have a say in whether or not the results are published.

Among the more successful wellness programs are smoking cessation programs; however, the proportion of smokers in a cessation program who quit, even for six months, seems surprisingly low, ranging between 5 and 15%.[200] The incidence of smoking in the United States is now about 20%, having declined steadily for several decades.[201] Those who continue to smoke may have the

196. Tu & Mayrell, *supra* note 67.

197. Rothstein & Harrell, *supra* note 194, at 949.

198. *See* Cahill & Perera, *supra* note 175; Sutherland et al., *supra* note 175 at 74S.

199. *See* K. Dickerson et al*., Publication Bias and Clinical Trials*, 8 CONTROL CLINICAL TRIALS 343, 351 (1987); Panayiotis A. Kyzas, Konstantinos T. Loizou & John P.A. Ioannidis, *Selective Reporting Biases in Cancer Prognostication Factor Studies*, 97 J. NAT'L CANCER INST. 1043, 1050 (2005); Erick H. Turner et al., *Selective Publication of Antidepressant Trials and Its Influence on Apparent Efficacy*, 358 NEW ENG. J. MED. 252, 256 (2008).

200. *See* TERRY F. PECHACEK ET. AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., BEST PRACTICES FOR COMPREHENSIVE TOBACCO CONTROL PROGRAMS—2007 (2007), *available at* http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/BestPractices_Complete.pdf.

201. AM. CANCER SOC'Y. CANCER FACTS & FIGURES 2011 35 (2011), *available at* http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-029771.pdf; Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human

most difficulty quitting. Relapse is common, even after "successful" cessation programs; it can take many tries for a smoker to quit permanently.[202] Most experts recommend comprehensive tobacco control programs that include taxation, public education campaigns, and legal restrictions on sales and locations for smoking.[203] Nonetheless, smoking cessation is a common wellness program goal, because the health benefits (apart from some weight gain) are well established.[204]

Programs to reduce blood pressure (to lower or prevent hypertension and ultimately heart disease), and to a lesser extent cholesterol levels (to prevent heart disease), may be perhaps easier to implement, partly because of the availability of reasonably effective pharmaceuticals.[205] Programs that eliminate employee cost-sharing for prescription drugs have succeeded in improving adherence to drugs that can prevent heart attacks.[206] Reducing risk factors for diabetes, however, has proved to be more difficult. The rising incidence of Type II diabetes has influenced the push for preventive health care and wellness programs. High blood sugar levels, along with high blood pressure and lipids, create risks for Type II diabetes, which in turn, is a risk factor for heart disease, stroke, kidney diseases, and other medical problems.[207] Many programs focus on reducing blood sugar levels, but a careful, randomized, controlled trial found that the population receiving intensive therapy to reduce its average blood sugar to normal levels (about 4

Servs., *Current Cigarette Smoking Prevalence Among Working Adults—United States, 2004-2010*, 60 MORTALITY & MORBIDITY WKLY. REP. 1305, 1305 (2011), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6038a2.htm.

202. *See* PECHACEK ET. AL., *supra* note 200.

203. *See* Kenneth Warner, *Tobacco Policy Research: Insights and Contributions to Public Health Policy*, in TOBACCO CONTROL POLICY 3, 13-15 (Kenneth Warner ed., 2006); PECHACEK ET. AL., *supra* note 200; *Tobacco Use*, GUIDE TO COMMUNITY PREVENTIVE SERVS. (Feb. 7, 2011), http://www.thecommunityguide.org/tobacco/index.html.

204. *See generally* INST. OF MED. OF THE NAT'L ACADS., ENDING THE TOBACCO PROBLEM: A BLUEPRINT FOR THE NATION (Richard D. Bonnie et al. eds., 2007); U.S. Surgeon Gen., U.S. DEP'T OF HEALTH & HUMAN SERVS., THE HEALTH CONSEQUENCES OF SMOKING: A REPORT OF THE SURGEON GENERAL (2004).

205. *See* Ara V. Chobanian et al., *The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure: The JNC 7 Report*, 289 JAMA 2560 (2003). *But see* ACCORD Study Grp., *Effects of Intensive Blood-Pressure Control in Type 2 Diabetes Mellitis*, 362 NEW ENG. J. MED. 1575, 1584 (2010) (finding that reducing blood pressure did not reduce the rate of fatal and nonfatal major cardiovascular events).

206. *See, e.g.*, Niteesh K. Choudry et al., *At Pitney Bowes, Value-Based Insurance Design Cut Copayment and Increased Drug Adherence*, 29 HEALTH AFFS. 1995, 1997-1998 (2010).

207. *See* Thomas Almdal et al., *The Independent Effect of Type 2 Diabetes Mellitus on Ischemic Heart Disease, Stroke, and Death: A Population-Based Study of 13,000 Men and Women with 20 Years of Follow-up*, 164 ARCHIVES INTERNAL MED. 1422 (2004).

to 6%) experienced more deaths than the group receiving standard therapy (2.6% v. 1.8%), which reduced its average level to about 7.5%.[208] These results contradicted the standard recommendations for diabetes control, and the researchers stopped the trial.[209] On the other hand, physical fitness may reduce the incidence of diabetes, even without weight loss.[210]

Significant weight loss appears to be the most difficult goal to achieve and maintain.[211] Short-term weight loss appears to be the most common result.[212] The average amount of weight lost in successful programs appears to be relatively small.[213] Of course, averages hide individual differences; some participants may have lost a great deal while others lost little or even gained weight. The real problem appears to be maintaining weight loss.[214] Participants often regain some or all of the weight they lose within a year or so.[215] There remains scientific uncertainty about the physiology of weight gain and loss. A recent study suggests that at least some people may have hormonal or other biological resistance to weight loss—possibly a built-in survival mechanism that served humanity well in prehistoric times of famine.[216] Sustained

208. Action to Control Cardiovascular Risk in Diabetes Study Grp., *Effects of Intensive Glucose Lowering in Type 2 Diabetes*, 358 NEW ENG. J. MED. 2545, 2545, 2550-51 (2008) (explaining that both populations began with an average blood sugar level of 8.1% and that comparative rates of death in the intensive versus standard therapy groups were 2.6% versus 1.8% for cardiac deaths and 5% versus 4% for all causes of death).

209. *Id.* at 2546.

210. *See* Chobanian et al., *supra* note 205; Steven N. Blair & Tim S. Church, *The Fitness, Obesity, and Health Equation: Is Physical Activity the Common Denominator?* 292 JAMA 1232 (2004).

211. James W. Anderson et al., *Long-Term Weight Loss Maintenance: A Meta-Analysis of U.S. Studies*, 74 AM. J. CLINICAL NUTRITION 579, 583 (2001).

212. *Id.*

213. *See, e.g.*, Ron Z. Goetzel et al., *Second-Year Results of an Obesity Prevention Program at The Dow Chemical Company*, 52 J. Occupational Envtl. Med. 291, 294 (2010) (reporting that wellness program participants weighed 1.3 pounds less than non-participants, primarily because non-participants gained an average of 1.3 pounds); Laurie M. Anderson et al., *The Effectiveness of Worksite Nutrition and Physical Activity Interventions for Controlling Employee Overweight and Obesity: A Systematic Review*, 37 AM. J. PREVENTIVE MED. 340, 350 (2009) (finding that studies of worksite programs achieved a pooled average weight loss of 2.8 pounds per person over six to twelve months).

214. Rena R. Wing & James O. Hill, *Successful Weight Loss Maintenance*, 21 ANN. REV. NUTRITION 323, 324, 336 (2001).

215. *Id.* at 325; Anderson et al., *supra* note 211, at 579; Leslie K. John et al., *Financial Incentives for Extended Weight Loss: A Randomized Controlled Trial*, 26 J. GEN. INTERN. MED. 621, 621 (2011); Melanie Warziski Turk et al., *Randomized Clinical Trials of Weight Loss Maintenance: A Review*, 24 J. CARDIOVASCULAR NURSING 58, 59 (2009).

216. Priya Suminthran et al., *Long Term Persistence of Hormonal Adaptions to Weight Loss*, 365 NEW ENG. J. MED. 1597, 1603 (2011). *See also* Paul S. MacLean et al., *Biology's*

weight loss appears to require life-style changes or many years of intensive management, possibly including medication to regulate hormonal control of appetite.[217] Indeed, the limited success with most programs may encourage the use of bariatric surgery.[218]

The health effects of weight loss are also mixed. Repeatedly losing and regaining weight (yo-yo dieting) seems unhealthy. There is even controversy about what constitutes a healthy weight.[219] Most studies have concluded that the overweight population does not have higher mortality rates than the normal weight population.[220] Rather, increased risks of death, and especially increased costs, primarily arise in the obese population, mostly concentrated in the so-called morbidly obese (BMI $\geq$ 40).[221] Compounding the confusion, some popular discussions of obesity include the category of overweight (BMI 25 < 30) with that of obesity (BMI $\geq$ 30).[222] In determining health effects and costs, however categorizing the overweight with the obese is an error.

Nonetheless, the population weight curve has been shifting slightly to the right in the past two decades, meaning that an increasing proportion of the population has moved from the normal weight category to the overweight category, and from overweight to obese.[223] The question is whether that matters—for the population's health or the nation's economy. Some scholars argue that adverse consequences of obesity are overblown.[224] The association between obesity and chronic diseases is well established, but the

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Response to Dieting: The Impetus for Weight Regain, 301 AM. J. PHYSIOLOGY—REGULATORY, INTEGRATIVE & COMP. PHYSIOLOGY R581 (2011).

217. *See* Thomas A. Wadden et al., *Four-Year Weight Losses in the Look AHEAD Study: Factors Associated with Long-Term Success*, 19 OBESITY 1987 (2011) (Framingham study reporting that women who lost weight gained more than those who did not).

218. *See* Joseph Proietto, *Why Is Treating Obesity So Difficult? Justification for the Role of Bariatric Surgery*, 195 MED. J. AUSTL. 144 (2011).

219. *See* PAUL F. CAMPOS, THE OBESITY MYTH 179 (2004).

220. John Cawley & Chad Meyerhoefer, *The Medical Care Costs of Obesity: An Instrumental Variables Approach* 3 (Nat'l Bureau of Econ. Research, Working Paper No. 16467, 2010), *available at* http://www.nber.org/papers/w16467.

221. *Id.* at 39; Kevin R. Fontaine et al., *Years of Life Lost Due to Obesity*, 289 JAMA 187, 189 (2003). Obesity is classified into 3 grades, based on BMI: grade 1, BMI 30≤35; grade 2, BMI 35≤40; and grade 3, BMI ≥40. Flegal et al., *supra* note 130, at 236.

222. *See, e.g.*, CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 10; Levi et al., *supra* note 142.

223. *See* Flegal et al., *supra* note 130, at 239; *U.S. Obesity Trends*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/obesity/data/trends.html (last updated July 21, 2011).

224. *See* MICHAEL GARD & JAN WRIGHT, THE OBESITY EPIDEMIC: SCIENCE, MORALITY AND IDEOLOGY 91-102 (2005) (analyzing the evidence); J. ERIC OLIVER, FAT POLITICS: THE REAL STORY BEHIND AMERICA'S OBESITY EPIDEMIC 23-27 (2006); PAUL F. CAMPOS, THE OBESITY MYTH 20-25 (2004).

actual relationship is less well understood. Does obesity cause chronic diseases or do chronic diseases lead to obesity? Is something else going on? Must the trend toward a larger population, so to speak, mean that the country will experience increasing personal illness and financial costs?

D. Evidence for Cost Savings

The literature abounds with reports of cost savings produced by wellness programs.[225] A recent meta-analysis of studies reported that wellness programs cost employers an average of $144 per employee per year and lowered annual medical costs by an average of $358 per employee per year, slightly lower than earlier reviews.[226] Overall, the evidence that wellness programs save money is more mixed.[227] Several studies report increases in some costs and decreases in others.[228] Recent evidence suggests that cost savings may depend on very intensive programs and substantial incentives.[229] Indeed, the most frequently cited examples of cost savings are from large employers that can afford to offer free services, like on-site gyms, or more intensive, individualized care programs.[230]

Whether particular wellness programs save money also depends on how costs are defined.[231] Costs typically include health insurance premiums, but may or may not include the employee's share of the premium. If the employer considers only its own premium contribution to be a cost, rather than the total premium, including the employee's contribution, the results may not reflect total costs.

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225. An often-cited study is Steven G. Aldana, *Financial Impact of Health Promotion Programs: A Comprehensive Review of the Literature*, 15 AM. J. HEALTH PROMOTION 296 (2001). Aldana's website states that he is the CEO and founder of WellSteps, a company that sells wellness programs. *Biography*, STEPHEN G. ALDANA PH.D., http://www.stevealdana.com/index_bio.php (last visited Nov. 9, 2011).

226. Katherine Baicher et al., *Workplace Wellness Programs Can Generate Savings*, 29 HEALTH AFFS. 304, 304 (2010) (reporting an average return on investment of $3.27 for medical costs per dollar spent and $2.73 per dollar spent for absenteeism).

227. *See* Rothstein & Harrell, *supra* note 194, at 948.

228. *See, e.g.*, Todd Gilmer, *Costs of Chronic Disease Management for Newly Insured Adults*, 49 MED. CARE e22-27 (2011) (reporting that annual inpatient costs were $1260 lower and outpatient costs were $723 greater, among participants in disease management).

229. *See* Tu & Mayrell, *supra* note 67, at 5.

230. *See, e.g.*, Ron Z. Goetzel et al., *The Long-Term Impact of Johnson & Johnson's Health & Wellness Program on Employee Health Risks*, 44 J. OCCUPATIONAL ENVTL. MED. 417 (2002); Rachel M. Henke et al., *Recent Experience in Health Promotion at Johnson & Johnson: Lower Health Spending, Strong Return on Investment*, 30 HEALTH AFFS. 490 (2011).

231. *See* Tu & Mayrell, *supra* note 67.

The costs of absenteeism and productivity may or may not be included or calculated separately. In addition, to determine savings, one must estimate what costs would have been without the program. That calculation may or may not take into account the effects of both internal and external changes that would have affected costs without the program. For example, if the employer changed the benefit plan to reduce overall premiums by reducing benefits, increasing deductibles or cost-sharing, or by increasing the employee's share of the premium, the employer's own costs would be reduced regardless of a wellness program. Similarly, the employer may have improved the work environment or moved to a different location that affects employee health or fitness.

V. IMPLICATIONS OF USING INSURANCE TO PROMOTE HEALTH

The ACA's encouragement of wellness programs has one advantage and several disadvantages. The advantage is largely symbolic—it highlights the value of preventive measures to improve health. Its disadvantages are both symbolic and practical. The symbolism of health promotion is clouded by the emphasis on personal responsibility for health. This symbolism is likely to permeate public policy because it is embodied in insurance, which in turn expresses powerful influences on social attitudes about collective versus personal responsibility. The ACA is structured to establish a community with equal access to care by requiring uniform group premium rates, guaranteeing all legal residents health coverage, and eliminating pre-existing condition exclusions and caps on claims.[232] This structure eliminates risk classifications that distinguish one individual from any other in any risk pool. Wellness programs that charge some individuals in the pool more than others reintroduce the very risk classification that the ACA rejected.[233] Thus, the message of the ACA's wellness provision is that there is an exception to the ACA's overall goal of ensuring near-universal access to care at the same group rates, and that exception is for people who fail to conform to an ideal of normal health status.

The use of financial incentives to adjust the price of insurance to individuals within a given risk pool can be viewed in quite different ways. On one hand, it can be seen as a new way for insurers

232. *See* Mariner, *supra* note 40 at 439. *See also supra* text accompanying notes 2, 55.
233. Mariner, *supra* note 12, at 222.

to encourage their policyholders to take care of the insured property (the person's body) so as not to cause abnormal wear and tear or loss. An analogy might be requiring property owners to install smoke detectors as a condition of homeowner's insurance coverage. In this view, using preventive services like disease-screening tests is analogous to installing smoke detectors, so that a person can detect an incipient disease in time to prevent serious damage. On the other hand, people are not property. Health risks are not as easily detected as fires. Even when they are, the means to control or prevent future diseases are not necessarily under a person's control.

Financial incentives make sense to encourage rational decisions among people who are in a position to respond voluntarily. However, physicians, not patients, make most decisions about medical care.[234] The "market" for medical care is unlike other consumer product markets, because the consumer does not choose what product to buy (except for certain elective services, such as cosmetic plastic surgery).[235] Rather, the consumer typically decides whether to accept or reject a physician's recommendation for diagnostic, therapeutic, or rehabilitative care. Furthermore, medical recommendations are unlike a salesman's recommendation about which automobile or refrigerator or even insurance policy to buy, because a patient may need medical care to survive in a way that is entirely different from the need for a new car or refrigerator. As Deborah Stone points out, patients do not "use" health care, in the sense that consumers "use" consumer goods.[236] Patients tend to receive whatever their physicians recommend. Therefore, attempts to reduce the demand for care would be better redirected to the providers who create the demand.[237] In this regard, increasing costs payable by patients, including increased premiums, deductibles, and co-payments, appears both ineffective

234. *See* Mark A. Hall, *Trust, Law and Medicine*, 55 STAN. L. REV. 463 (2002).

235. *See id*; Mariner, *supra* note 24.

236. Deborah Stone, *Moral Hazard*, 36 J. HEALTH POL. POL'Y & L. 887, 894 (2011).

237. Examples of current efforts to encourage physicians to provide more cost-effective care include proposed new payment methods, such as bundled or global payments and accountable care organizations. See the CMS final regulations for accountable care organizations for the Medicare Shared Savings Program. U.S. Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Medicare Shared Savings Program: Accountable Care Organizations, Final Rule, 76 Fed. Reg. 67,802 (Nov. 2, 2011) (codified at 42 C.F.R. pt. 425); Aricca D. Van Citters et al., *Four Health Care Organizations' Efforts to Improve Patient Care and Reduce Costs*, COMMONWEALTH FUND, Jan. 13, 2012, http://www.commonwealthfund.org/Publications/Case-Studies/2012/Jan/Four-Health-Care-Organizations.aspx.

and unfair. Cost-sharing can discourage people from obtaining medical care at exactly the time when they need care.[238]

It may be objected that people do choose to "use" preventive care, because preventive services, unlike most medical care, are not recommended by physicians to treat an acute medical problem. It is true that patients can decide whether and when to get preventive services. To this extent, financial incentives can influence the receipt of preventive care.[239] Exactly what services to get, however, remains essentially a medical determination.

It might also be objected that patients bear some responsibility for their medical needs, to which physicians respond by recommending care. Indeed, this appears to be the sentiment underlying claims that unhealthy people are responsible for excessive health care costs.[240] There is no doubt that we can affect our own health in many ways; we should listen to our grandmother's advice on staying healthy. Nonetheless, the influences of our genes, environment, income, and opportunities constrict our ability to follow that advice to a greater or lesser extent.[241]

There are practical problems with locating wellness programs within insurance. Their benefits and risks depend significantly on how they are structured—whether and what kinds of incentives they use. Programs that offer free services at the workplace have few disadvantages, unless the employer monitors their use and considers the information in retention and promotion decisions.[242] Although incentives appear to improve results, they also invite discrimination against those who are least able to afford higher insurance costs.

Employer workplace wellness programs have the advantage of being generally accessible to employees and can be administered as part of the employer's health benefit plans. However, these advantages may be outweighed by practical concerns, especially for private sector employers. With unemployment at more than 8% (not counting those who have given up looking for work), the proportion of the nonelderly population with any prospect of em-

238. Stone, *supra* note 236, at 891.

239. *See* text accompanying *supra* notes 183-88.

240. *See* Abigail C. Saguy & Kevin W. Riley, *Weighing Both Sides: Morality, Mortality, and Framing the Contests over Obesity*, 30 J. HEALTH POL. POL'Y & L. 879, 890-91 (2005).

241. *See supra* note 119.

242. *See infra* text accompanying notes 258-62.

ployer-sponsored health coverage is declining.[243] First, not all employers offer health plans, much less wellness programs.[244] High employee turnover can dissuade an employer from offering health benefits. If Congress eliminates the employers' tax deduction for contributions to benefit plans (and the exclusion from employee income of the total contribution), there will be less reason for employers to offer a plan.[245] Small employers in difficult economic times are hard-pressed to provide benefits, even with the incentives provided by the ACA.[246] Their employees will need to find coverage in commercial plans offered through the health insurance exchanges or Medicaid. Insurers who offer plans through an exchange may not offer wellness programs, especially if the required essential health benefits prove to be costly.[247] Those insurers may have fewer incentives to include wellness program elements, because their covered population may be somewhat transient.

Second, employer plans do not necessarily cover all employees. Many employers have temporary or part-time employees who need not be offered benefits.[248] In the current economy, employers may rely on such part-time employees and be reluctant to offer them special benefits. Temporary employees come and go and may work for different employers, either simultaneously or one after another. Employee turnover makes it difficult for both employees and employers to reap the long-term benefits of wellness programs. This is exacerbated in businesses with a majority of low-

243. BUREAU OF LABOR STATISTICS, U.S. DEP'T. OF LABOR, THE EMPLOYMENT SITUATION—JANUARY 2012 (2012), *available at* http://www.bls.gov/news.release/pdf/empsit.pdf. As of January 2012, the employment rate was 8.3%. *Id.*

244. Fronstin, *supra* note 151, at 5 (reporting that 58.7% of the nonelderly population had employer-sponsored health benefits in 2010).

245. *See* Stephen Langel, *'Super Committee' Looks to Health for Savings to Reduce Deficits*, 30 HEALTH AFFS. 1819 (2011) (noting budget pressure to obtain an estimated $250 billion in tax losses).

246. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUCATIONAL TRUST, *supra* note 164, at 34.

247. Health insurers offering plans through health insurance exchanges must cover "essential health benefits" to qualify as acceptable plans. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311, 124 Stat. 119 (2010), The definition of essential health benefits is quite broad and is to be based on a typical employer plan. *Id.* The Secretary of Health and Human Services, who is responsible for defining such benefits, has allowed the states to establish their own benchmarks for defining benefit. U.S. Dep't of Health and Human Servs., *Essential Health Benefits: HHS Informational Bulletin*, HEALTHCARE.GOV, http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html (last updated Feb. 24, 2012).

248. Clyde W. Summers, *Contingent Employment in the United States*, 18 COMP. LAB. L.J. 503, 506 (1997).

wage workers. Besides being hard-pressed to afford coverage, low-wage workers may change employers more frequently than high-paid employees. Changes in income may enable employees to qualify for Medicaid in one year, but not the next.[249] These shifts create inconsistencies in coverage and, presumably, participation in wellness programs.

Third, not all eligible employees join their employer's or union plan.[250] Some may get coverage from a spouse's health plan, but the most common reasons for not having health insurance are the cost of the plan and beliefs that insurance is not necessary.[251] The price of insurance is unlikely to decline significantly after the ACA becomes fully effective.[252] Although the ACA provides incentives for small businesses to offer health benefits, in the current economy, with diminished demand and the continued rise in health care costs, insurance premiums may remain out of reach for many small businesses.[253]

Finally, workplace programs won't directly help family members, including children, unless the employee has family coverage and the wellness program makes family members eligible to participate. Employers may require all participating members of the family to meet wellness goals in order to earn rewards. Of course, parents may apply what they learn in the workplace to their family members.

Public employers, especially state and local government employees, may have fewer of the above disadvantages, because their employees are more likely to remain in government employment

249. *See* Sommers & Rosenbaum, *supra* note 109.

250. *See* Jean M. Abraham & Roger Feldman, *Taking Up or Turning Down: New Estimates of Household Demand for Employee-Sponsored Health Insurance*, 47 INQUIRY 17 (2010); Fronstin, *supra* note 151, at 1 (finding that 51.5% of individuals with employer-based health benefits had coverage in their own names in 2010).

251. *See* Fronstin, *supra* note 151; CARMEN DENAVAS-WALT ET AL., U.S. DEP'T OF COMMERCE, CURRENT POPULATION REPORTS: CONSUMER INCOME: INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2010 (2011), *available at* http://www.census.gov/prod/2008pubs/p60-235.pdf; Mark W. Stanton, *Employer-Sponsored Health Insurance: Trends in Cost and Access*, RESEARCH IN ACTION (Agency for Healthcare Research & Quality, Rockville, Md.), SEPT. 2004, *available at* http://www.ahrq.gov/research/empspria/empspria.htm.

252. *See* Patricia F. Adams et al., *Summary Health Statistics for the U.S. Population: National Health Interview Survey, 2009*, VITAL HEALTH STAT. (Ctrs. for Disease Control & Prevention, Washington, D.C.), Dec. 2010, at 1, *available at* http://www.cdc.gov/nchs/data/series/sr_10/sr10_248.pdf (finding that almost half the nonelderly population did not have health insurance because of its cost).

253. *See* Edward A. Miller, *Affordability of Health Insurance to Small Business: Implications of the Patient Protection and Affordable Care Act*, 36 J. HEALTH POL. POL'Y & L. 539 (2011).

for longer periods of time. Many government employees are in collective bargaining units, which may be able to negotiate the wellness programs that employees seek.[254] In contrast, state Medicaid beneficiaries are especially likely to have interrupted eligibility.[255]

In summary, it is probably overly optimistic to expect employer programs to achieve the kind of results that would substantially improve overall health or reduce the costs of chronic diseases. Behavior change is difficult, especially when it is not self-motivated.[256] Medicare's experience with disease management programs shows how hard, and expensive, it can be.[257]

A different disadvantage of placing wellness programs within employer benefit plans is their potential for discrimination against employees who are considered to be irresponsible about their health. One possibility may be increased scrutiny by fellow workers, creating pressure to lose weight or stop smoking, for example. Employees should be aware of the existence of wellness programs and may observe and comment on the behavior of fellow employees and whether they have visible changes. The surveillance literature suggests that mechanisms for monitoring behavior can produce conformity among the "watched."[258] Incorporating wellness programs into employee benefit programs may heighten awareness of the differential costs for employees who do not meet health standards. This can encourage the idea that individual employees with specific conditions are raising the cost of health insurance to the rest of the workforce.[259] The fact that conditions like obesity, but not sports injuries, for example, are singled out

254. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, USDL-12-0094, UNION MEMBERS—2011 (2011), *available at* http://www.bls.gov/news.release/pdf/union2.pdf.

255. *See* Sommers & Rosenbaum, *supra* note 109.

256. *See* Harald Schmidt et al., *Carrots, Sticks, and Health Care Reform—Problems with Wellness Incentives*, 302 NEW ENG. J. MED. e3 (2009). *See generally*, M. J. Grawitch et al., *The Path to a Healthy Workplace: A Critical Review Linking Healthy Workplace Practices, Employee Well-being, and Organizational Improvements*, 58 CONSULTING PSYCHOL. J.: PRAC. & RES. 129 (2006).

257. Machlin et al., *supra* note 108, at 1. About 45% of people with public insurance have at least 2 chronic conditions, compared with 1/3 of people with private insurance and 16% of uninsured persons. *Id.*

258. *See, e.g.*, Kevin D. Haggerty & Richard V. Ericson, *The New Politics of Surveillance and Visibility*, *in* THE NEW POLITICS OF SURVEILLANCE AND VISIBILITY 1, 22 (Kevin D. Haggerty & Richard V. Ericson eds., 2005).

259. *See* KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUCATIONAL TRUST, *supra* note 164, at 169 (reporting that 32% of large firms and 9% of small firms offering wellness programs use insurance claims "to identify individuals and encourage wellness participation").

for attention, can create a distorted impression of the costs of medical care. Social pressures arising in the workplace may be severe.

Of greater significance is the possibility that employers will use health status as a criterion for employment or promotion.[260] People with chronic diseases can face barriers to employment, whether because of their actual or perceived lower productivity, disability costs, or simple prejudice.[261] If insurance-based wellness programs encourage norms of personal responsibility for one's own health, as may be expected, existing prejudices may be more easily justified on ostensibly objective grounds. Those who fail to manage their own health risks can be seen as out of control and outside the normal pool of responsible employees. Thus, defensible prejudice can rationalize discriminatory hiring policies. [262]

The law tends to support employers' prerogatives to hire whomever they wish and on such terms as they choose. Employers can change the terms of employment whenever they choose for employees who have no written contract.[263] Only 11.9% of the U.S. workforce (14.7 million people) was covered by a collective bargaining agreement in 2010.[264] This suggests that most of the 240 million employees in the United States are employees at will.[265] In theory, the employee at will, like the employer, is free to leave for

260. Amy B. Monahan & Daniel Schwarcz, *Will Employers Undermine Health Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 128 (2011).

261. *See* OLIVER, *supra* note 224, at 61.

262. Linda Hamilton Krieger, *The Content of Our Categories: A Cognitive Bias Approach to Discrimination and Equal Employment Opportunity*, 47 STAN. L. REV. 1161, 1176 (1995) (distinguishing prejudice, which refers to feelings about others, such as pity, disgust, or reverence, from discrimination, which means actions taken on the basis of prejudice, such as avoidance or exclusion; also noting some disagreement on the boundaries between the concepts).

263. Summers, *supra* note 248, at 504 (written contracts include individual contracts, which are used primarily for executives, and collective bargaining agreements).

264. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, USDL-12-0094, UNION MEMBERS—2011 (2011), *available at* http://www.bls.gov/news.release/pdf/union2.pdf. This represents a decline from 20% (17.7 million) in 1983. *Id.* Slightly less than half of these (7.1 million) hold private sector jobs. *Id.*

265. Employment at will is a common law doctrine that presumes that any employee without an individual or union contract may, at any time, quit the job or be terminated by the employer for good cause, for no reason, or even for a morally wrong reason. Payne v. W. & Atl. R.R. Co., 81 Tenn. 507, 518 (Tenn. 1884). Employees who are hired without a definite term of employment are presumed to be employees at will. Pickell v. Ariz. Components Co., 931 P.2d 1184, 1186 (Colo. 1997); Madden v. Omega Optical, Inc., 683 A.2d 386, 389 (Vt. 1996); Hatfield v. Health Mgmt. Assocs. of W. Va., Inc., 672 S.E.2d 395, 401 (W. Va. 2008); Garcia v. UniWyo Fed. Credit Union, 920 P.2d 642, 645 (Wyo. 1996). *See* 5 J.D. LEE & BARRY LINDAHL, *Employment at-will doctrine*, *in* MODERN TORT LAW: LIABILITY AND LITIGATION § 44.1 (2d ed. 2011) (collecting cases). For employment data, see BUREAU OF LABOR STATISTICS, *supra* note 243.

any reason or no reason, which allows a mobile workforce to take advantage of new opportunities.[266] In practice, however, especially in economically hard times, the scarcity of alternative jobs gives employees far less freedom to quit than the law presumes.[267]

Both legislation and common law doctrine have created exceptions to the employee at will doctrine, selectively limiting the employer's freedom to hire and fire.[268] Courts have construed employee handbooks and policies as constituting a contract that defines the terms and conditions of continued employment.[269] It is unlikely that the provisions of a voluntary wellness program in the health benefits plan could be interpreted as a requirement. However, if an employer were to require participation or the achievement of specific health standards, these could be considered conditions of employment. Some courts have required termination only for cause where the employment circumstances created a reasonable expectation.[270] In practice, such exceptions often oblige employers to offer a reason for terminating an employee in order to avoid a claim of wrongful discharge for a prohibited reason.[271] These erosions of the employment at will doctrine create an incentive for employers to track employee behavior to find a socially acceptable reason for termination if the employer wants or needs to remove employees or jobs.[272] Health insurance costs may prove to be such a reason.

Statutory limits on employment decisions are better known and also can be a foundation for claims of wrongful discharge against public policy. The most important, Title VII of the Civil Rights

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266. H.G. WOOD, A TREATISE ON THE LAW OF MASTER & SERVANT: COVERING THE RELATION, DUTIES AND LIABILITIES OF EMPLOYERS AND EMPLOYEES § 134 (1877).

267. Lawrence E. Blades, *Employment at Will vs. Individual Freedom: On Limiting the Abusive Exercise of Employer Power*, 67 COLUM. L. REV. 1404, 1405 (1967).

268. Common law limitations, such as those based on public policy, typically are not relevant to wellness programs and are not discussed here. *See generally*, *Employment At-Will Exceptions by States*, NAT'L CONF. OF ST. LEGISLATURES (April 2008), http://www.ncsl.org/?tabid=13339.

269. *See, e.g.*, Toussaint v. Blue Cross & Blue Shield of Mich., 292 N.W.2d 880, 885 (Mich. 1980); Thompson v. St. Regis Paper Co., 685 P.2d 1081, 1087 (Wash. 1984) (en banc). Fewer than half of the states have implied a covenant of good faith and fair dealing to employment at will relationships, because the duty arose primarily when interpreting a contract. Suburban Hosp., Inc. v. Dwiggins, 596 A.2d 1069, 1077 (Md. 1991).

270. Woolley v. Hoffmann-La Roche, Inc., 491 A.2d 1257, 1264 (N.J. 1985), *modified on reh'g*, 499 A.2d 515 (N.J. 1985).

271. Paula G. Ardelean et al., *The Development of Employment Rights and Responsibilities*, 25 ABA J. LAB. & EMP. L. 449, 451 (2010). According to the authors, this can discourage employers from taking a chance on new employees or firing unproductive employees. *Id.* at 457.

272. *See generally id.*

Act of 1964, prohibits discrimination in employment on the basis of race, color, national origin, religion and sex.[273] The federal Age Discrimination in Employment Act,[274] the American's with Disabilities Act ("ADA"),[275] the Family and Medical Leave Act,[276] and the Genetic Information Non-discrimination Act ("GINA")[277] all restrict employer decision making. However, such statutes typically do not apply to small businesses with fewer than fifteen or twenty employees, and small businesses employ the majority of American workers. [278]

A recent federal district court decision underscored the employer's remaining freedom to require employees to sacrifice family and perhaps health as a condition of advancement.[279] Judge Loretta A. Preska dismissed claims of gender discrimination against Bloomberg L.P., finding that "[t]he law does not require companies to ignore or stop valuing dedication, however unhealthy that may be for family life."[280] Her decision noted that Bloomberg "explicitly makes all-out dedication its expectation,"[281] but concluded that "the law does not mandate 'work-life' balance."[282] The decision emphasized that the employee, rather than the employer, had a choice: "[a] female employee is free to choose to dedicate herself to the company at any cost, and, so far as this record suggests, she will rise in this organization accordingly."[283] The decision suggests that poor employment conditions are acceptable as long as they apply to everyone.

Adding wellness programs to employee compensation packages may invite similar pressures. The relationship between insurance underwriting and wellness programs is illustrated by a challenge

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273. 42 U.S.C. § 2000e-2(a) (2006). The Civil Rights Act of 1964 is applicable to employers with at least fifteen employees. § 2000e.

274. 29 U.S.C. §§ 621-634 (2006) (applicable to employers with at least twenty employees).

275. 42 U.S.C. §§ 12101-12213.

276. 29 U.S.C. §§ 2601-2654.

277. Pub. L. No. 110-233, 122 Stat. 881 (2008) (codified in scattered sections of 26 U.S.C., 29 U.S.C. and 42 U.S.C.) (applicable to employers with at least fifteen employees).

278. States have enacted similar laws, often covering additional protected classes. *See* Ardelean, *supra* note 271, at 453.

279. Equal Employ't Opportunity Comm'n v. Bloomberg L.P., 778 F. Supp. 2d 458, 485 (S.D.N.Y. 2011).

280. *Bloomberg*, 778 F. Supp. 2d at 486.

281. *Id.* at 485.

282. *Id.*

283. *Id.* at 486. Apparently, the company treated all leaves of absence equally, so that women who took maternity leave were no worse off than others who took leaves for other reasons. *Id.* at 484.

to a wellness program established by Broward County, Florida, through its health insurer. [284] The County deducted twenty dollars from the bi-weekly paycheck of each employee who did not complete a health risk assessment and biometric screening.[285] The insurer identified employees with asthma, hypertension, diabetes, congestive heart failure, or kidney disease and offered them a disease management coaching program.[286] Employees who participated in the coaching program could receive some medications free.[287] Bradley Seff, an employee who was charged the twenty dollar fees, claimed that the program violated the ADA by requiring employees to submit themselves to medical examinations and questioning.[288] A federal district court in Florida dismissed the claim, finding that the program was not discriminatory, because it was a legitimate method of assessing risks in order to plan future health insurance coverage.[289] To do so, the court relied on the need for risk classification in insurance coverage.[290]

The court found that the wellness program was part of the health insurance plan, which is quite correct.[291] The ADA permits insurers to conduct bona fide risk classification and underwriting.[292] That provision was intended to allow premium differences that are based on actuarial differences in claims costs.[293] The court considered that provision to be a safe harbor from the ADA's prohibition on medical inquiries and examinations.[294] It concluded that the program was based on "insurance and risk assessment principles," which were permitted by the ADA, and not on "some

284. Seff v. Broward Cnty., 778 F. Supp. 2d 1370, 1371 (S.D. Fla. 2011).

285. *Seff*, 778 F. Supp 2d. at 1372.

286. *Id.*

287. *Id.*

288. *Id.* Under the ADA:

> a covered entity shall not require a medical examination and shall not make inquiries of an employee as to whether such employee is an individual with a disability or as to the nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity.

42 U.S.C. § 12112(d)(4)(A) (2010).

289. *Seff*, 778 F. Supp. 2d at 1374.

290. *Id.*

291. *Id.* at 1373. The court also found that, alternatively, the wellness program by itself could be considered to be a benefit plan, which would not change the analysis. *Id.* at 1373 n.5.

292. 42 U.S.C. § 12201(c).

293. Barnes v. Benham Grp., Inc., 22 F. Supp. 2d 1013, 1020 (D. Minn. 1998).

294. *Seff*, 778 F. Supp. 2d at 1375. The court agreed with plaintiff that the wellness program was "not entirely optional," since non-participants were charged a biweekly fee. *Id.* at 1373. It is doubtful, but not impossible, that this conclusion was material to the court's decision. Others could just as easily conclude that the same program was voluntary.

independent desire for a healthy workforce."[295] The insurer, therefore, could alter costs based on an employee's health risks. Of course, it was the employer, not the insurer, that charged the fee, but the court noted that the employer was managing an employee benefit plan and could make financial decisions based on risk classifications. This interpretation of the ADA would conflict with the ACA and HIPAA's prohibition on discrimination based on health factors, were it not for the wellness program exception.[296]

GINA and the HIPAA Privacy Regulations may have the most significant application to wellness programs, because many programs collect personal health information about individuals.[297] One of the most common elements of employer wellness programs is the Health Risk Assessment (HRA), which typically asks the employee to identify whether she has any health risks from a list and often includes biometric measures, such as blood tests.[298] Completing an HRA is often the prerequisite to receiving wellness program services, especially those intended to provide individualized advice or coaching.[299] GINA prohibits both employer group health plans and health insurers providing group coverage from "adjust[ing] premium or contribution amounts for the group covered under such plan on the basis of genetic information."[300] If employees volunteer genetic information that affects a wellness program reward, the prohibition can come into play.[301]

A key difference between anti-discrimination laws and common law doctrine is that the former creates protected classes defined primarily (although not exclusively—religion is an exception) on immutable traits of the employee, like race, age, and genetics, while common law doctrine focuses on the employer's reasons or the employee's actions, without regard to such inherent traits.[302] Thus, employees who are not discriminated against on the basis of

295. *Id.* at 1375.

296. *See infra* text accompanying notes 56-81.

297. Tu & Mayrell, *supra* note 67, at 2-3.

298. *Id.*; KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUCATIONAL TRUST, *supra* note 164, at 169. *See* Anderson v. City of Taylor, No. 04-74345, 2006 U.S. Dist. LEXIS 38075, at *12-18 (E.D. Mich. June 9, 2006) (finding that a blood draw pursuant to a mandatory wellness program for city fire fighters could be challenged as a violation of the employees' rights to protection against unreasonable searches and seizures under the Fourth Amendment).

299. Tu & Mayrell, *supra* note 67, at 2.

300. Genetic Information Non-discrimination Act, Pub. L. No. 110-233, §§ 101(a), 102(a), 122 Stat. 881, 883, 888 (2008).

301. Bard, *supra* note 12.

302. *See supra* notes 268-71.

such protected traits are not eligible for statutory remedies for employment discrimination. However, apart from the ADA, being at risk of a chronic disease is not a characteristic of a protected class, and even the ADA would not protect people who are merely at risk of future disease, unless the risk factor itself, such as hypertension, qualified as an impairment that affected a major life activity or the employer perceived the person as having a disability.[303]

Some employers are already refusing to hire people who use tobacco, even if only outside the workplace.[304] The reason most often given is to promote the health of their employees.[305] In some cases, an employer's aversion to smoking in the workplace has become an aversion to smokers, even if the employees do not smoke at work. Decades of public education about the risks of smoking has made it socially acceptable to refuse employment to smokers.[306] People who are obese or even overweight may experience similar reactions. Prejudice against people who are obese is hardly a recent phenomenon.[307] A New York court found that a prosecutor was entitled to strike a juror on the grounds that she was overweight, because he believed that heavy-set people tend to be very sympathetic toward any defendant."[308] Overweight children are often the target of teasing and discrimination.[309] A recent proposal to characterize childhood obesity as grounds for charging parents with child neglect breaks new ground by assuming that a child's

303. 42 U.S.C. § 12102(1) (2010).

304. *See, e.g.*, City of N. Miami v. Kurtz, 653 So. 2d 1025, 1026 (Fla. 1995), (upholding refusal to hire smoker); Rodrigues v. EG Sys., Inc., 639 F. Supp. 2d 131, 134 (D. Mass. 2009). Ten years after *Kurtz*, the City of North Miami rescinded its ban when it could not get enough applicants. Linda Florea, *St. Cloud Hires Smokers Again*, ORLANDO SENTINEL, May 24, 2006, http://articles.orlandosentinel.com/2006-05-24/news/OWNOSMOKE24_1_1_smoking-policy-cloud-tobacco. The World Health Organization was perhaps the most prominent entity to adopt a policy of not hiring smokers. *WHO Policy on Non-recruitment of Smokers or Other Tobacco Users: Frequently Asked Questions,* WORLD HEALTH ORG., http://www.who.int/employment/FAQs_smoking_English.pdf (last visited Nov. 15, 2011).

305. *Id.*

306. Jennifer Stuber et al., *Smoking and the Emergence of a Stigmatized Social Status*, 67 SOC. SCI. & MED. 420 (2008).

307. DEBORAH L. RHODE, THE BEAUTY BIAS: THE INJUSTICE OF APPEARANCE IN LIFE AND LAW (2010); SONDRA SOLOVAY, TIPPING THE SCALES OF JUSTICE: FIGHTING WEIGHT-BASED DISCRIMINATION (2000); Elizabeth E. Theran, *"Free to be Arbitrary and . . . Capricious": Weight-Based Discrimination and the Logic of American Antidiscrimination Law*, 11 CORNELL J.L. & PUB. POL'Y 113, 152 (2001).

308. People v. Dolphy, 685 N.Y.S.2d 485, 487 (N.Y. App. Div. 1999).

309. Helen A. Hayden-Wade et al., *Prevalence, Characteristics, and Correlates of Teasing Experiences Among Overweight Children vs. Non-overweight Peers*, 13 OBESITY RESEARCH 1381 (2005).

weight could be controlled by a responsible parent.[310] So far, the British Medical Association has rejected it, but the idea could resurface.[311]

In the past decade, however, several states have enacted legislation to protect employees from discrimination on the basis of employee behavior outside the workplace.[312] While some states prohibit discrimination on the basis of tobacco use at home, other states expand protection to any lawful conduct outside the workplace.[313] Like earlier anti-discrimination laws, these statutes appear to be intended to eliminate adverse employment decisions that are based on factors having nothing to do with job performance. So far, there have not been similar reactions to the kinds of behavior changes encouraged by wellness programs, although critics point out that such policies not only create stigma, but also deprive qualified people of employment.[314]

Monitoring employees for behaviors beyond job performance obviously raises privacy questions. Although the workplace is not a privacy zone, employees have long expected that their lives outside the workplace are none of their employer's business. That, too, is changing. The ADA limits, but does not eliminate, affected employers' access to medical information about employees.[315] Employers may require employees to take a medical examination or employers may ask about medical conditions as long as these examinations are "job related and consistent with business necessity."[316] The targets of wellness programs are not generally related to job performance. Nonetheless, the growing salience of health to job performance may expand the sphere of permissible inquiries. Moreover, to the extent that business necessity includes financial constraints on the employer's budget for labor, employees who are

310. Russell M. Viner et al., *Childhood Protection and Obesity: Framework for Practice*, 341 BRIT. MED. J. 3074 (2010).

311. Andrew Cole & Zosia Kmietowicz, *BMA Rejects Call for Parents of Obese Children to Be Charged with Neglect*, 334 BRIT. MED. J. 1343 (2007).

312. John Malouff et al., *US Laws That Protect Tobacco Users from Employment Discrimination*, 2 TOBACCO CONTROL 132 (1993).

313. *Id.*

314. Brian Houle & Michael Siegel, *Smoker-Free Workplace Policies: Developing a Model of Public Health Consequences of Workplace Policies Barring Employment to Smokers*, 18 TOBACCO CONTROL 64 (2009); Leonard Glantz, *Smoke Got in Their Eyes*, WASH. POST, Dec. 18, 2005, http://washingtonpost.com/wp-dyn/content/article/2005/12/17/AR2005121700945.html.

315. 42 U.S.C. § 12112(d)(2)(A) (2010) (prohibiting medical inquiries and examinations before an offer of employment). The Family Medical Leave Act limits employers' access to reasons for an employee's medical leave. 29 C.F.R. §§ 825.306(a)(2)-(3), 825.307(a) (2011).

316. 42 U.S.C. § 12112(d)(4)(A).

believed to generate high health insurance or absentee expenses may be subject to increasing monitoring or dismissal. Of course, the ADA protects employees with a disability from termination solely for reasons of cost, but the class protected, like those specified in other federal anti-discrimination laws, remains only a subset of all workers in the country. Moreover, it may not be difficult for employers to avoid hiring individuals who appear obese or have obvious personal characteristics that the employer believes will lead to higher health costs.

Maintaining appropriate confidentiality of medical records can be difficult when employees and their dependents are enrolled in employer-sponsored health plans. Health insurers, like hospitals and other care providers, are obligated to keep medical records confidential and not disclose them without patient consent under HIPAA.[317] Thus, group health plans have an obligation not to disclose claims information to an employer.[318] But employers themselves are not necessarily subject to the HIPAA Privacy Rule, which applies only to "covered entities" who keep medical records.[319] Employers who establish self-insured health plans, rather than buying a commercial insurance policy, are not deemed to keep records or to be insurers or providers.[320] The self-insured plan is governed by a trust, which, in theory, is separate from the employer.[321] Nonetheless, it may be unrealistic to expect that an employer, who may be the plan fiduciary as well as the boss, can keep an impermeable wall between employee performance records and its health plan or other employee medical records. Companies may not receive individual data, but they do analyze aggregate employee results. Smaller companies may be able to guess who is and is not participating in a wellness program. Where incentives are offered, the payroll department must issue checks or deduct higher premiums for health insurance from the employee's wages. Employers have direct access to other records, such as long-term disability and worker compensation claims. They also search social media, such as Facebook, and use background checks to glean

317. 45 C.F.R. §§ 164.102-06, 164.500-34 (2011).
318. *Id.* § 164.504(f)(2)(ii)(C).
319. *Id.* § 160.103.
320. 29 U.S.C. § 1144(b)(2)(B) (2010).
321. *Id.* § 1102 (2010) (establishment of plan and designation of fiduciary). Many employers engage a commercial insurer to act as a third party administrator to handle claims and the collection of premiums and cost-sharing.

information about prospective and current employees.[322] Note, however, that employers must keep confidential certain records that they are entitled to maintain pursuant to the ADA and the FMLA.[323]

Still, employees may legitimately worry that medical information that might threaten their jobs could be easily accessed by employers, whether deliberately, through sloppy practices, or as a result of genuine confusion about their obligations. Employers who lawfully learn something about an employee's medical condition are generally free to use it to make employment decisions, unless otherwise limited by federal or state anti-discrimination laws.

There is a certain irony to the notion that the ADA, which was enacted to protect people with disabilities from being excluded from or disadvantaged in employment, would be interpreted to permit penalizing employees who are, at best, at risk for a disease or disability. Discrimination on the basis of health factors may be as irrational as discrimination on the basis of disability. Employers and insurers who ask applicants and employees about their health risks for purposes of determining the amounts employees pay for insurance are encouraged to impose differential costs on those with risks. The ADA safe harbor was apparently intended to permit insurers to charge actuarially fair rates, based on a group's claims experience. A Florida district court found that the wellness program was "based on the theory that encouraging employees to get involved in their own healthcare leads to a more healthy population that costs less to insure."[324] Other courts may accept the same theory, especially since judges are not typically in a position to critically analyze the data on prevention and may see only the more enthusiastic summaries of advocates for preventive care. This posture may encourage financial discrimination against employees who are believed to have medical conditions that would raise insurance costs.

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322. Ardelean, *supra* note 271, at 463-67 (noting that employers may also monitor employee computers and, with some exceptions, email at work). *See* LORI B. ANDREWS, I KNOW WHO YOU ARE AND I SAW WHAT YOU DID 122-23, 132 (2011).

323. The ADA requires employers who obtain medical information about an applicant to keep it confidential in a separate medical file, available only to supervisors and managers only as needed for work restrictions, accommodations, and emergency treatment. 42 U.S.C. § 12112(d)(3)(B) (2010). Equal Employment Opportunity Commission regulations now prohibit discrimination against employees on the basis of genetic information their employers find on social networks. 29 C.F.R. § 1635.8 (2010).

324. Seff v. Broward County, 778 F. Supp. 2d 1370, 1374 (S.D. Fla. 2011).

By increasing the permissible amount of incentives for wellness programs, the ACA encourages more financial incentives—cash payments, insurance premium discounts, and surcharges.[325] Indeed, it may encourage programs that require people to meet specific targets, such as losing a certain number of pounds, lowering their blood sugar to a particular level, or stopping smoking. If enough employees do not participate in voluntary programs or fail to achieve health targets, will employers begin to require participation? Or might employers find reasons to avoid hiring such individuals?

Discriminatory employment practices, even if legal, are likely to hurt the most disadvantaged among us. The target population for wellness programs overlaps to a substantial degree with the population least able to afford health insurance.[326] Chronic diseases, obesity, and tobacco use are more prevalent in the lower socioeconomic classes than in the general population.[327] About half of those with disabilities who work earn poverty-level wages.[328] While it might seem helpful to create financial incentives for them to reduce their health risks, they may be in the weakest position to do so. If these individuals do not succeed in qualifying for discounts or rewards, they will pay a larger share of their smaller income to obtain the same health insurance available to everyone else in the pool. In the worst case, they will not find employment at all, yet income can be a better predictor of health than the health factors that wellness programs seek to improve.

Employee programs that succeed in preventing illness may have value to employers for two reasons. First, employers may save money in the short-term if employees are more productive and less prone to absenteeism. Second, some costs of medical care may be shifted into the future, most probably after retirement, and onto the federal government, which pays the costs of Medicare. Thus, while employers may gain some benefits, the government is likely to pay the costs. How should this factor into the analysis? There is no risk spreading between the public and private sector, except to the extent that employers and employees contribute Medicare and Social Security taxes. To more fairly spread the risk between

325. Tu & Mayrell, *supra* note 67.

326. *See* Jacobi, *supra* note 188.

327. *See* Kristin Voigt, *Smoking and Social Justice*, 3 PUB. HEALTH ETHICS 91 (2010) (noting that a disproportionate number of smokers are from disadvantaged populations).

328. Peiyun She & Gina A. Livermore, MATERIAL HARDSHIP, POVERTY, AND DISABILITY AMONG WORKING-AGE ADULTS (2006).

employers and government, Medicare could be increased to compensate the government for the additional expenses it is likely to incur as a result of the employer's healthier employees. This kind of risk spreading, of course, would surely be opposed by employers (and probably employees, too), who seek to reduce their costs, not increase their taxes. Yet, it would more fairly represent the responsibility for health care across the population's lifetime.

VI. PREVENTION OUTSIDE INSURANCE

Situating the locus for health improvement at the level of the individual sends a message that individuals are responsible for their own health, regardless of the pressures and obstacles they face. Whether this is true in any case depends upon the problem being addressed. If the problem is that people don't know their risks or the benefits they could receive by changing their behavior, then the solution is to let them know. Whose responsibility is that? It seems unlikely that employers and insurers should be the responsible party. If the problem is that they understand their risk, but don't change, whose problem is that? Is there a duty to be healthy? If it is a problem that endangers society as whole, such as irrational or violent behavior, government can justifiably control the individual.[329] Here, however, the problem appears to be the cost of care. The cost of care is determined more by health care providers than individuals. If the government wants to reduce costs, it would be more effective to regulate those who set the fees, instead of spreading the costs back onto those who use the services.

Behavior science literature demonstrates that it is especially difficult to engage in anything that feels like a deprivation today if the benefit is far in the future, as is the case with most wellness programs.[330] For those who want to change, but need a push, the default system of paternalism may be welcome. If the problem is the cost of care, however, we need better information about the relative costs of different health risks. Moreover, it is difficult to rely on individuals to change their health status, because the fac-

329. *See* Gard & Wright, *supra* note 224, at 181 ("Being defined as 'overweight' means that a whole range of institutions . . . are provided with the right and indeed the responsibility to identify people so categorized, or people who might be 'at risk' of such categorizations, and to regulate their behaviors.").

330. THALER & SUNSTEIN, *supra* note 168.

tors that mediate health status are numerous and complex, including social conditions that promote inequality.[331]

To the extent that responsibility for health rests with private insurance plans—private products—opportunities for improving health focus on micro-relationships between employee and employer or enrollee and insurer. This excludes macro-level, structural social and economic influences on health, which can only be significantly modified by government action. Such influences include the built environment, agricultural policy, and the changing diet produced by global food distribution.[332] Most observers recognize these macro influences, but changing them is a long, arduous process. Thus, the focus remains on individual behavior, either as the fallback position or as a symbolic effort. For example, after constructing several estimates of chronic disease costs, the World Economic Forum's disappointing recommendations for "the 'best buy' interventions" for prevention were fourteen standard recommendations for changing personal behavior, preventive medical care, taxes, and education.[333] This has significant implications for social attitudes toward people who are not in good health. Using insurance to attempt to modify their condition fosters the idea that they are at fault and must either change or pay a penalty. Social attitudes about personal responsibility for risk may permanently change social norms and make it even more difficult to change the underlying environment. Finally, it may further marginalize the disadvantaged by segregating them into a new class of the "unhealthy."

Currently, opinion polls indicate that the public is ambivalent about whether people with certain health risks should pay for insurance. Some polls show that a majority believe that people who smoke or are overweight should pay higher insurance premiums

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331. *See supra* note 118.

332. *See, e.g.*, Mickey Chopra, *Globalization and Food: Implications for the Promotion of "Healthy" Diets, in* GLOBALIZATION, DIETS & NONCOMMUNICABLE DISEASES (2002), *available at* http://whqlibdoc.who.int/publications/9241590416.pdf; Corinna Hawkes, *Uneven Dietary Development: Linking the Policies and Processes of Globalization with the Nutrition Transition, Obesity and Diet-related Chronic Diseases*, 2 GLOBALIZATION & HEALTH (2006); David Price, Allyson M. Pollock & Jean Shaoul, *How the World Trade Organisation Is Shaping Domestic Policies in Health Care*, 354 LANCET 1889 (1999).

333. BLOOM ET AL., *supra* note 8, at 37. The recommendations were taxes on tobacco and alcohol, smoke-free workplaces and public places, health information, bans on tobacco and alcohol advertising and promotion, restricted access to alcohol, reduced salt intake, replacing trans fats, mass advertising on diet and physical activity, counseling and drug therapy (including aspirin) for those at risk of cardiovascular disease, hepatitis B immunization, and screening and treatment of precancerous lesions to prevent cervical cancer. *Id.*

because they will generate more health care costs. Other polls find that the majority believe that such a practice would be unfair.[334] The more people become habituated to the idea that health care costs are a matter of personal responsibility, the more likely they are to accept differential pricing. And if differential pricing is acceptable, then perhaps more coercive measures can also be accepted. The law's protection of civil liberties makes clear that people should not be forced to do things that have negligible social benefit and certainly not solely for economic benefit. So, government can require people to get immunized against a severe, contagious disease in order to prevent an epidemic, but cannot require people to take drugs as part of a research study that might benefit mankind, just because it would be cheaper to do so without getting their agreement. Similarly, government cannot force a person into a housing project in order to save money, but can institutionalize a person who is dangerous to others by reason of a mental illness that makes it unlikely that he will be able to control his own violent behavior.

Wellness program incentive systems range from minor and marginally effective, to major and possibly coercive. The ACA's wellness program exception represents an attempt to reconcile two inconsistent goals: enabling penalties and rewards based on health risks without deviating from the general principle that health insurance should not be based on risk classifications. Although researchers are earnestly trying to find the combination of services and incentives that produce the best results, all programs (other than those providing free services and facilities) create insurance premiums based on an individual's risk classification. The use of incentives to participate does not necessarily make a program voluntary, because rewards and penalties are two sides of the same coin.[335] In short, the incentives permitted for wellness programs are likely to be too crude to significantly improve the population's health or save money, and they pose an unnecessary threat to the underlying goals of the ACA. They do not belong in an insurance system that avoids risk classification. Instead, health insurance should cover all actual claims without adjust-

334. *Drop in Public Support of Higher Healthcare Costs for Smokers, Obese*, ETHICS NEWSLINE (Inst. For Global Ethics, Rockport, Me.), Nov. 05, 2007, *available at* http://www.globalethics.org/newsline/2007/11/05/drop-in-public-support-of-higher-healthcare-costs-for-smokers-obese/.

335. Mariner, *supra* notes 12; Erika Blacksher, *Carrots and Sticks to Promote Healthy Behaviors: A Policy Update*, 38 HASTINGS CTR. REP. 13 (2008).

ments for risk factors that may or may not affect the claims rates. A better approach would eliminate the wellness program exception and rely on publicly available preventive and social services to promote health.

So, what is the best way to share responsibility for improving the population's health? The market economy distributes private goods. Public goods are typically distributed or regulated by government. Public investments in health are generally believed to improve economic conditions and vice versa.[336] The most effective ways to improve the population's health are likely to lie in improving the social determinants of health. In principle, there is substantial support for public programs to provide preventive services, safer social and built environments, research, and education. As a result, a better question involves how government could make it possible for people to improve their health. Publicly provided services have the advantage of being available to everyone, regardless of employment or insurance status. Individuals can avail themselves of the services without being subjected to intrusive monitoring by employers. This approach can encourage good health without penalizing those who either cannot improve or do not care to change. The services could extend to other chronic diseases of importance, like arthritis, Alzheimer's disease, and depression.[337] Indeed, they could and should be coordinated with programs to increase employment and income and improve housing and education, which are likely to reduce health risks to a larger degree than insurance wellness programs.[338] A community-

336. William Jack & Maureen Lewis, *Health Investments and Economic Growth: Macroeconomic Evidence and Microeconomic Foundations* (World Bank, Working Paper 4877, 2009).

337. Arthritis, back conditions, and heart disease accounted for 41% of disabilities in the United States in 2005. OFFICE OF THE SURGEON GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., THE SURGEON GENERAL'S CALL TO ACTION TO IMPROVE THE HEALTH AND WELLNESS OF PERSONS WITH DISABILITIES (2005), *available at* http://www.surgeongeneral.gov/library/disabilities/calltoaction/calltoaction.pdf. See also Ronald C. Kessler et al., *The Epidemiology of Major Depressive Disorder: Results from the National Comorbidity Survey Replication*, 289 JAMA 3095 (2003) (noting that depression is a major cause of disability).

338. *See, e.g.*, WENDY E. PARMET, POPULATIONS, PUBLIC HEALTH, AND THE LAW (2009); Jens Ludwig et al., *Neighborhoods, Obesity, and Diabetes—A Randomized Social Experiment*, 365 NEW ENG. J. MED. 1509 (2011) (explaining how women and children randomly assigned by HUD to receive vouchers to move to low-poverty housing areas slightly lowered their rates of obesity and high blood sugar, compared with those who did not receive vouchers and could choose their own housing area); *Communities Putting Prevention to Work: CDC Awards $372.8 Million to 44 Communities*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/features/chronicpreventiongrants/ (last visited Nov. 17, 2011).

based or public health approach recognizes that promoting health is a social responsibility to make a healthy life possible, rather than an individual duty to stay healthy and save money.

Employers can still play a role. Those who offer free services, such as on-site fitness centers, safe buildings, and perhaps quiet rooms for napping or stress reduction exercises, as a benefit of employment independent of health insurance, should be rewarded, perhaps by tax deductions. Employers might be encouraged to address issues beyond smoking and obesity, such as stress reduction, scheduling, and depression.[339] But, by removing risk classification from employee insurance plans, the potential for discrimination against employees is reduced.

VII. CONCLUSION

The function of preventive care is to improve health, not necessarily to save money. This is a valuable goal in its own right. The ACA's encouragement of wellness programs, however, links health promotion to cost savings in ways that may be both ineffective and counterproductive. The ACA frames health as a personal responsibility, which is inconsistent with its overall goal of universal access to health care.[340] It encourages the use of public and private insurance to goad individuals to conform to behaviors that are believed to save money by preventing chronic diseases. It is far from clear whether wellness programs can achieve those goals to any significant degree, both because the programs are highly variable in producing behavioral change and because substantial savings are unlikely over the long run.

Skepticism about the value of wellness programs, however, is not an indictment of the goal of improving heath or encouraging the use of preventive services. It is, rather, a critique of the use of insurance as the means to accomplish those goals. Insurance reflects what we find socially acceptable, which risks we are willing to share, and which risks remain the responsibility of individuals. Insurance also shapes public perceptions of risk. The United States has a history of characterizing health as a personal respon-

339. *See* Walter F. Stewart et al., *Cost of Lost Productive Work Time Among US Workers with Depression*, 289 JAMA 3135 (2003).

340. CHOICES, VALUES, AND FRAMES (Daniel Kahneman & Amos Teversky eds., 2000).

sibility.[341] The ACA can change that characterization by enabling everyone to have access to care without regard to why care is needed. It can do so by eliminating risk classifications based on health status.[342] The wellness program exception, however, reintroduces risk rating back into the insurance pool, but only for certain disfavored conditions.[343] Its danger lies in encouraging the view that those conditions are personal faults that can be penalized. It can transform prejudices based on questionable data into justifiable classifications based on health. One's health status may become a socially acceptable basis for discrimination.

341. Stanley J. Reiser, *Responsibility for Personal Health: A Historical Perspective*, 10 J. MED. PHIL. 7 (1985) (noting that historical trends in U.S. favored personal responsibility and self-sufficiency with limited government interference).

342. Mariner, *supra* note 40.

343. Mariner, *supra* note 12.